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A REPORT BASED ON A STUDY OF
THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

By

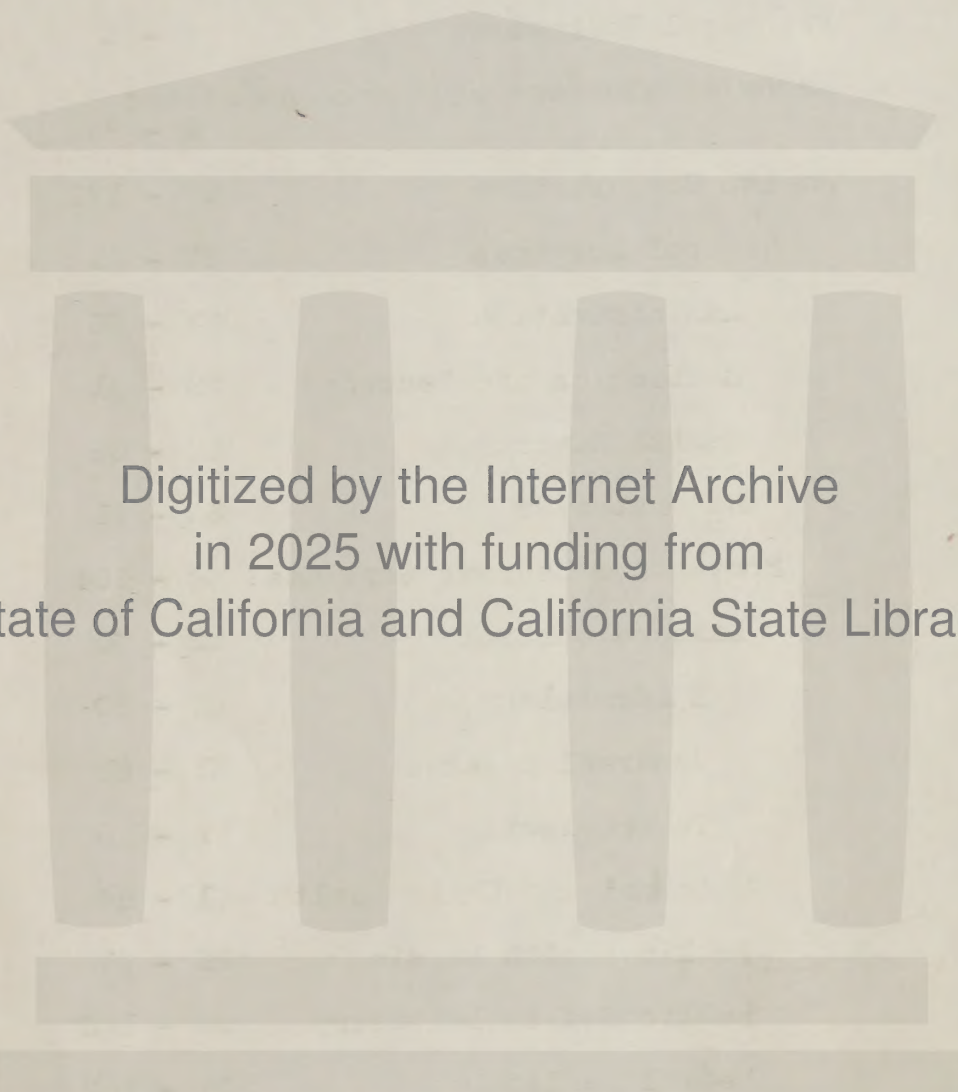
THE AMERICAN PUBLIC HEALTH ASSOCIATION

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THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

The study of which this is a report was made at the request of the Chief Administrative Officer of San Francisco by the American Public Health Association through its field * staff. It was financed by a special appropriation approved by the Mayor and made by the County Board of Supervisors.

Although sponsored by the American Public Health Association, the statements in this report are those of the field staff and do not necessarily represent the opinion of the Association.

The field staff acknowledges with deep appreciation the splendid cooperation and assistance of the Chief Administrative Officer and of the Director of Public Health and all members of the San Francisco Department of Public Health.

Any appraisal or evaluation of the San Francisco Department of Public Health would be remiss if it failed to point out the fact that this department is very different from most other city or city-county health departments. The San Francisco Department of Public Health is unique, or at least unusual, in that it operates under an unusual type of governmental set-up and in that its scope of interest and functioning is much broader than that of most health departments.

San Francisco city and San Francisco county (whose geographic limits are coterminal) are governed by a county type of government but with some differences. The principal governing body is the City-County Board of Supervisors composed of 11 persons elected for four year terms. The Board of Supervisors enacts all legislation applying to both city and county and makes all appropriations. There is no city council. There is a Mayor elected for a four year term who is eligible for re-election. There is a Chief Administrative Officer appointed by the Mayor for an indefinite term of office. He may be removed from office only by a two-thirds vote of the Board and only after charges have been preferred. The two principal administrative officers are the Mayor and the Chief Administrative Officer. Certain city-county departments are under the control of the Mayor, while others are under the Chief Administrative Officer. Certain elective officers, such as the City Attorney, the Assessor, the District Attorney,

* Carl E. Buck, Dr. P. H., Field Director
George T. Palmer, Dr. P. H., Associate Field Director

the Sheriff, the Treasurer, and the Public Defender, are responsible directly to the electorate. The Mayor is responsible for the departments of Police, Fire, Parks, Art, Recreation, Library, Welfare Commission, Public Utilities, City Planning, Civil Service, Education, the Retirement Board, and the Board of Permit Appeals. The Controller is appointed by the Mayor and must be confirmed by the Board of Supervisors. The Chief Administrative Officer is responsible for the departments of Public Health, Finance and Records, Purchasing, Real Estate, Public Works, Electricity, the Street Traffic Advisory Board, the Coroner's Office, Horticultural Inspection, the Coordinating Council, and Weights and Measures.

The San Francisco Department of Public Health carries on all the activities normally found in a large city health department,* and is also responsible for the administration of the San Francisco Hospital (including a general hospital of some 575 beds, a Tuberculosis Unit with 380 beds, an Isolation Unit of 54 beds, and a Psychiatric Unit of 52 beds), the Laguna Honda Home (a home for the aged housing about 1116 ambulatory cases and an infirmary or chronic hospital of about 786 beds), the Hassler Health Home (a tuberculosis sanatorium with 268 beds), the Emergency Hospital Service (6 hospitals with ambulance service), and the City Physicians' Service; administration, statistics, laboratories communicable disease control, including the acute communicable diseases, tuberculosis and the venereal diseases, child welfare, mental hygiene, public health dentistry, public health nursing, and environmental sanitation, including food and sanitation, milk and meat supervision and plumbing).

Present employees of the Department total about 1560.

The enlarged scope of activities of this department obviously makes the problem of effectively coordinated administration far more complex and difficult than it is in most other health departments with more limited functions.

This is essentially an administrative study. This report makes no attempt to discuss in detail each activity or to evaluate detailed professional or technical procedures. It does call attention to major strengths and weaknesses and makes suggestions and recommendations for administrative changes which would seem likely to result in more effective service without injustice to the taxpayer.

At the very outset, it may be well to point out principal strengths and weaknesses as a means of focusing

* except public health engineering and health education.

attention on methods of meeting unmet needs.

Principal Strengths

The San Francisco Department of Health has as its Director a physician with an exceptionally broad and rich background of training and experience in public health and public health administration; far above the training and experience of most health officers.

The average qualifications of training and experience of professional personnel is probably superior to the average found in many if not most other health departments.

The policy in San Francisco of combining the administration of public preventive and health promotional services and public curative services in a single department of government is in keeping with recent trends and seems destined to provide a more effectively coordinated service and a better total service to the community than would be provided through separate administrative units.

In the central office or department of health exclusive of institutions, hereafter referred to as health conservation, the most highly developed and effective service seems to be Venereal Disease Control. Not only is the control program well planned and conducted, including a program of health education but the psychiatric program (which might eventually become an important part of a broad program of mental health) seems to be rendering a very valuable service.

The program for the control and supervision of Milk is of high calibre and merits special commendation.

Certain aspects of the Child Welfare program, notably in the fields of school health supervision, and well child health conferences, are particularly well developed and administered.

The continuously progressive effort to place public health nursing on a generalized basis is worthy of special mention.

The program in the field of Food and Sanitation supervision has shown great improvement in the past few years, due largely to a change from a highly specialized to a more generalized service.

In spite of great difficulties, attributable to the war, particularly in man power shortages, patients at the

San Francisco County Hospital apparently continue to receive a superior type of care, far better than that obtained in the average hospital. This is due to the fact that medical care is provided by the visiting staffs of the medical schools.

The San Francisco Hospital, through careful scrutiny and study of methods of detailed administration, has been able to effect substantial economies with no loss of service and in some instances with a resultant improvement of service. Additional studies, notably in the serving of meals, in laundry service, and in major mechanical operations, give promise of effecting still further economies and improvement of service.

The Emergency Hospital Service, with its six hospitals and accompanying ambulance service, is the most comprehensive and elaborate which your surveyors have ever seen. The program combines emergency service with a very considerable amount of service which would elsewhere be thought of as a function of hospital outpatient departments.

Principal Weaknesses

The greatest weakness of the San Francisco Department of Public Health is that it is altogether too much of a "one man" organization. The Director takes far more personal responsibility for administration, including administrative details, than would seem either necessary or justifiable. Three of the cardinal principles of good administration are: (a) that questions involving administration be channeled properly, (b) that administrative responsibility be delegated to persons occupying administrative positions, and (c) that persons occupying such positions be given the backing and support of their superior officers until or unless they have been proven incapable of making sound administrative decisions. There is a failure to observe all three of these cardinal principles. This failure is due in part to the fact that there are vacancies in certain key administrative positions, in part because too many bureau, divisional, and institutional directors are responsible directly and solely to the Director of Public Health, possibly in part to a lack of confidence of the Director in persons occupying administrative positions, but mainly, in the opinion of your surveyors, to an unwillingness to delegate authority and to give persons in administrative positions the backing and support which they have a right to expect. If persons in administrative positions prove unable to make sound decisions, they ought not to occupy administrative positions but they should be given the opportunity of proving themselves capable or incapable.

The organization of the Department is, from the standpoint of administration, unwieldy in that the various bureau directors and independent divisions (of which there are some 13) and institutional directors are all responsible.

directly and solely to the Director of Public Health. This makes a total of 18 persons responsible directly to the Director.

Although the charter provides for an Advisory Board of Health, the Board has not been called together for several years.

There are no regular periodic conferences of persons occupying administrative positions, which can do so much to smooth out administrative difficulties, clarify policies, and develop effective teamwork. While there are special in service training programs in certain fields, such as public health nursing and food and sanitation, there are no departmental wide programs designed to keep personnel informed on the newer developments in preventive medicine and health promotion.

Professional personnel of the Department occupying administrative positions are neither encouraged nor permitted to attend national and other meetings of the professional groups to which they belong.

The methods of budget preparation and budget hearings are very weak. Bureau, institutional and divisional directors are merely given the opportunity of submitting, to the Director of Public Health, their requests for budget changes. No provision is made for a discussion of budget requirements between the Director of Public Health, the Business Manager, and the several bureau, institutional and divisional directors. Budget hearings with the Chief Administrative Officer, the Mayor, and the Finance Committee of the County Board of Supervisors are usually attended only by the Director of Public Health and the Business Manager. Occasionally, but only occasionally, are other members of the Health Department invited. The entire procedure is undemocratic, autocratic and not conducive to the best interests of the Department or the services which it renders.

There are two laboratories, one bacteriologic, the other chemical, housed separately, and without a single director paid an adequate salary. The bacteriologic laboratory has adequate space and seems to be reasonably adequately staffed, except perhaps for dishwashers, yet it apparently has the reputation throughout the Department of being uncooperative. The laboratory is examining an unnecessarily large number of specimens for the possible presence of diphtheria bacilli.

The program in epidemiology is well conducted and fulfills its functions effectively, but there is, in our opinion, a considerable waste of medical time. Some of the work now being done by physicians - epidemiologists - could be carried on just as effectively by public health nurses.

Much of the work in the field of tuberculosis control is excellent but the program, taken as a whole, lacks coordination and unification of planning.

The failure to enforce quarantine for tuberculosis, in short, to insist on the hospitalization of cases of active tuberculosis - is an extraordinary fundamental weakness of the tuberculosis control program.

The Department has no bureau of health education.

The Department has no public health engineer.

While the program in the field of Food and Sanitation has been greatly improved, it could be improved still further by generalizing completely its inspectorial services.

Although activities in birth and death registration and statistics are closely related, they are in the San Francisco Department of Health administered separately.

Physicians employed full time by the Department of Health do not receive from the city adequate insurance against possible suits.

The relationship between the Superintendent of the San Francisco Hospital and the visiting medical staff is not clearly defined nor is the Superintendent's authority to establish intake and discharge policies as clear cut and definite as it should be. The Superintendent is not given either the authority or the backing and support which he needs to administer the hospital effectively.

The present policy, (established by ordinance) of carrying psychiatric cases from the sheriff's office in detention at the San Francisco Hospital - without treatment-pending their transfer to other institutions, makes the handling of such cases difficult if they need treatment.

The Civil Service Commission has decreed that there should be a Bureau of Dairy and Abattoir Inspection and that a veterinarian should be its director. This is not a logical combination. The two services of milk control and supervision and meat inspection are totally different and involve the use of personnel of different training. There should be two separate bureaus. The meat inspection service should be directed by a veterinarian. The control and supervision of milk need not be directed by a veterinarian. Most of our effective milk control officers in the United States are not veterinarians but have had special training in this highly specialized field.

The present salary schedules, as established by Civil Service, have created grave injustices in several categories, most notably in the relationships between general clerk-stenographers and general clerk-typists and public health nurses, between public health nurses and social workers, and between ambulance drivers and emergency hospital stewards.

The salary schedule for public health nurses is \$175. - \$200. and for general clerk-stenographers and general clerk-typists \$160.-\$200. While there is a slight difference in the beginning salary, the top salary is the same, which is certainly an injustice to the public health nurse who has had to undergo a period of training vastly longer and more difficult than that of the clerk or stenographer. The salary of the social worker is \$175.-\$215. The beginning salary is the same, but at the end of 4 years the social worker will be getting \$215. as compared with \$200. for the public health nurse. This is unjust. While the social worker requires more training than the clerk, the training is less than that of the public health nurse. The ambulance driver and the emergency hospital steward have the same salary schedule, \$175.-\$210. This is a grave injustice since the steward has vastly greater responsibilities and must have far more training than the driver.

The practice of the San Francisco Civil Service Commission of presenting but a single name to fill a vacancy or a new position for which there is a Civil Service list is not in line with better modern Civil Service practices and can be, and sometimes is, a serious deterrent to getting the right person for a given position. To be sure, the employer has the right of rejecting the employee during the probationary period, but not infrequently the employer knows at the very outset that the particular individual whom Civil Service has certified for the position will not be a satisfactory member of the team. The employer ought not to be required to take such a person. It is the unalterable conviction of your surveyors (and they have observed a good many civil service systems) that the employer should be given the choice of at least three persons wherever there are Civil Service lists for such positions.

In our opinion, there are at least five other major weaknesses of the San Francisco Civil Service system. They are:-

(1.) In professional categories, particularly for persons to be selected for key administrative positions, there is not enough difference between minimum and maximum salary. In general we have no fault to find with the minimum salary but the maximum is frequently not sufficiently high to recruit or to retain the best person available for the position. (a notable example of this is to be found in the salary schedule for the assistant director of public

health. The minimum salary is high enough, but the maximum is only \$100. higher).

(2.) The present Civil Service rule of employing an individual at the minimum salary, regardless of qualifications of training and experience, is a serious block to the recruitment of superior persons. (The position of Assistant Director of Public Health will serve as an excellent illustration. If that position were open today and the only person available was a young person of good training but with limited experience, who, however, appeared to possess real potentiality for the future, the minimum salary would be sufficient. If, however, a person was available with good training and years of successful experience as a public health administrator - in short, a proven top-notch person - the minimum salary would certainly not be sufficient to interest him and, even if it were, the fact that the maximum he could obtain is only \$100. more than the minimum would make him decide against taking the position.

(3.) The present system of giving automatic increases in salary based solely on length of service and not on demonstrated ability is, in our opinion, wrong and inevitably tends toward a mediocre service. Persons who have demonstrated exceptional ability should be granted salary increases above the ordinary incremental increases based on length of service. Any system on which promotion is based largely on length of service rather than demonstrated ability leaves out the element of competition which has been the keynote to the phenomenal progress of American industry.

(4.) We are completely in accord with the policy of employing the persons who live in San Francisco provided they meet the necessary qualifications of training and experience. However, we believe that residence requirements should be waived whenever it is impossible to find San Francisco residents with required qualifications.

(5.) Present Civil Service qualifications and examinations for professional positions give no assurance of recruiting adequately trained personnel.

MAJOR CONCLUSIONS AND RECOMMENDATIONS

The remainder of this report will deal largely with Major Conclusions and Recommendations concerning Organization, Administration, and Policies - questions which affect the entire department - together with a brief discussion of the various activities carried on by the Department under such major headings as Health Conservation, General Services, Preventive Medical Services, Environmental Sanitation, Institutions, and City Physicians' Services.

ORGANIZATION, ADMINISTRATION, AND POLICIES

As pointed out in the section on Weaknesses, there are too many persons in administrative positions responsible directly and solely to the Director of Public Health without any machinery for coordination except through the Director himself. This involves a total of 18 persons, including 9 bureau directors, 4 division chiefs, 4 institutional superintendents, and the chief city physician. This type of organization tends toward a "one man" domination and makes administration unnecessarily unwieldy and complicated. A nationally known business administrator has said that no chief executive can be expected to administer adequately and effectively the work of more than six other executives if those executives are carrying on work of real scope and value.

As a means of facilitating and simplifying good administration, it is recommended:-

- (1.) THAT, THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH BE REORGANIZED IN ACCORDANCE WITH THE FOLLOWING ORGANIZATIONAL CHART.

It will be noted that the proposed organization provides for two branches of the Department, (1) the Health Conservation Branch (now referred to as the "Central Office") with an Assistant Director of Public Health as its administrative officer (this position is now a "Military Leave" vacancy) and (2) the Medical Care Branch with an Assistant Director of Public Health as its administrative officer. This would be a new position.

THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

CHIEF ADMINISTRATIVE
OFFICER

BOARD OF
HEALTH

DIRECTOR
OF PUBLIC HEALTH

HEALTH CONSERVATION BRANCH

MEDICAL CARE BRANCH

ASSISTANT DIRECTOR
OF PUBLIC HEALTH

ASSISTANT DIRECTOR
OF PUBLIC HEALTH

SECTION OF GENERAL SERVICES

BUREAUS OF

GENERAL ADMINIST. BUS. MAN. PERSONNEL ACCOUNTING	STATISTICS AND RECORDS	LABORA TORIES	HEALTH EDUCATION
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SAN FRANCISCO HOSPITAL	LAGUNA HONDA HOME	HASSLER HEALTH HOME	EMERG ENCY HOSPITAL SERVICE	CITY PHYSICIANS OFFICE
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SECTION OF PREVENTIVE MEDICAL SERVICES

BUREAUS OF

DISEASE CONTROL EPID. V. D. T. B.	MATERNAL AND CHILD HEALTH	PUBLIC HEALTH DENTISTRY	PUBLIC HEALTH NURSING	MENTAL HEALTH	ADULT HEALTH INCLUDING INDUSTRIAL HYGIENE
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SECTION OF ENV. SANITATION

BUREAUS OF

FOOD AND SANITATION	MILK	MEAT	PLUMBING
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————— = DIRECT RESPONSIBILITY
----- = RECIPROCAL WORKING RELATIONSHIP

In accordance with this plan the Health Conservation Branch of the Department would include three sections, (1) the Section of Administration, or, preferable, the Section of General Services, (2) the Section of Preventive Medical Services, and (3) the Section of Environmental Sanitation.

The Section of General Services would include the four bureaus of (1) Administration, including business management, personnel, and accounting. (2) Statistics and Records (Birth and death registration, vital statistics, morbidity statistics, and service records of the entire department), (3) Laboratories (combining the bacteriologic and chemical laboratories with a director (new position), and (4) Health Education (new bureau).

The Section on Preventive Medical Services would include the bureaus of (1) Disease Control (new title) with its divisions of Epidemiology, Venereal Disease, and Tuberculosis, (2) Maternal and Child Health (new title to add maternal health to its present functions of infant, pre-school, and school health), (3) Public Health Dentistry (taken away from Maternal and Child Health because public health dentistry may well involve more than dentistry for mothers and children), (4) Mental Health (removed from Maternal and Child Health so that it may, as it should, broaden its scope to include adults as well as children), (5) Public Health Nursing, and (6) Adult Health including Industrial Hygiene (it may not be feasible to establish this bureau immediately, but if San Francisco continues to be an important industrial center - as it seems destined to - there should be a Bureau of Adult Health which should concern itself not only with industrial hazards and occupational diseases but with the health of all persons gainfully employed and their families).

The Section on Environmental Sanitation would include the bureaus of (1) Food and Sanitation (which should be completely generalized by combining the present classifications of Market-Food and Housing Industrial Inspectors into a single classification of Public Health Inspectors), (2) Milk Control and Supervision (with a Director specially trained and experienced in milk control but who need not be a veterinarian), and (4) Plumbing Inspection.

The Section on Environmental Sanitation should be under the general supervision of a well trained and experienced full-time public health engineer (new position), who should concern himself not only with general administration but also with the engineering aspects of the entire department.

There should also be in the personnel of the Bureau of Food and Sanitation an entomologist (either a well trained entomologist or a well trained inspector who has been given

special training in entomology) to give special attention to insect vectors of disease.

The Assistant Director of Public Health in charge of the Medical Care Branch of the Department would have under his supervision and administration the Superintendent of the San Francisco Hospital, the Laguna Honda Home, the Hassler Health Home, the Emergency Hospital Service and the City Physicians' Office.

The several advantages of this plan of organization are:-

- (a) It enables the Director to administer his entire Department through a small number of executive officers.
- (b) It avoids a large number of independent administrative units and enables the Director to correlate the work of the Department more efficiently.
- (c) It defines clearly the chain of responsibility of the directors of the several bureaus and divisions of the Department.
- (d) It centralizes the direction of bureaus and divisions having close inter-relationships by placing administrative responsibility in the office of a single section director, who, in turn, interprets the program and needs of these bureaus and divisions to the Director.

This plan of organization can be put into effect immediately, even though its complete implementation may take considerable time. The plan is flexible in that it provides a means of promoting a few persons who have demonstrated exceptional administrative ability, or for the employment, if indicated, of new administrative personnel. For example, the placement of bureaus in an overall section to which they logically seem to belong provides a means of promoting to the position of section director any particularly capable administrator who may be found in these several bureaus or divisions. Also, under this plan it will not be necessary to make an immediate or permanent decision in appointing a section director.

One point which should be clearly borne in mind by those in charge of administration, particularly Civil Service administrators, is that persons in charge of various activities should receive salaries commensurate with their professional qualifications of training, experience, and demonstrated ability and not solely in accordance with the plan of administration. For example, it is recommended that the Bureau of Disease Control consist of Divisions of Epidemiology, Venereal Diseases, and

Tuberculosis. The persons in charge of these divisions should receive salaries in keeping with their training and experience in a specialty, not on the basis of their serving as division chiefs rather than bureau directors. A division chief, if his training and experience warranted, might well receive a higher salary than a bureau director.

To further facilitate good administration, it is recommended:-

- (2) THAT THE BASIC PLANS AND POLICIES OF THE DEPARTMENT BE CLEARLY DEFINED TO ALL PERSONS IN THE DEPARTMENT OCCUPYING ADMINISTRATIVE POSITIONS.

An Administrative manual will be found extremely helpful in obtaining the above objective.

- (3) THAT ALL QUESTIONS INVOLVING ADMINISTRATIVE DECISIONS BE REFERRED TO THE DIRECTOR OF THE ACTIVITY TO WHICH THE QUESTION PERTAINS.
- (4) THAT THE AUTHORITY AND RESPONSIBILITY FOR ADMINISTERING ANY GIVEN ACTIVITY BE DELEGATED BY THE DIRECTOR OF PUBLIC HEALTH TO THE PERSON IN CHARGE OF THAT ACTIVITY.
- (5) THAT THE DIRECTOR GIVE BACKING AND SUPPORT TO PERSONS OCCUPYING ADMINISTRATIVE POSITIONS UNTIL OR UNLESS SUCH PERSONS PROVE INCAPABLE OF MAKING SOUND DECISIONS.

- (6.) THAT ALL QUESTIONS WHICH MIGHT INVOLVE DECISIONS NOT IN KEEPING WITH ESTABLISHED PLANS AND POLICIES OF THE DEPARTMENT BE REFERRED TO THE DIRECTOR OF PUBLIC HEALTH FOR DECISION.

To still further strengthen administration, it is recommended:-

- (7.) THAT THERE BE REGULARLY SCHEDULED STAFF MEETINGS, AT LEAST ONCE A MONTH, PREFERABLY EVERY TWO WEEKS, OF ALL PERSONS OCCUPYING ADMINISTRATIVE POSITIONS.

Well planned and well conducted staff conferences are extremely helpful in smoothing out administrative difficulties, in planning programs, in bringing about effective teamwork, and in developing an esprit de corps.

In addition to staff conferences, which are essentially for discussing current activities and problems, every large health department should have an in-service educational program; a program conducted primarily by members of the Department itself, but with occasional guest instructors, designed to keep the administrative staff currently informed as to the newer developments in the field of preventive medicine and health promotion.

It is recommended:-

- (8) THAT A CONTINUOUS, PERIODIC, YEAR AROUND PROGRAM OF IN-SERVICE TRAINING BE CONDUCTED FOR THE PURPOSE OF KEEPING PERSONNEL OF THE DEPARTMENT CURRENTLY INFORMED ON THE NEWER DEVELOPMENTS IN THE FIELD OF PREVENTIVE MEDICINE AND HEALTH PROMOTION.

It is further recommended:-

- (9.) THAT PROFESSIONAL PERSONNEL IN ADMINISTRATIVE POSITIONS BE NOT MERELY PERMITTED BUT ENCOURAGED TO ATTEND NATIONAL AND OTHER MEETINGS OF THE PROFESSIONAL GROUPS TO WHICH THEY BELONG AND THAT APPROPRIATIONS BE GRANTED FOR ATTENDANCE AT SUCH MEETINGS WITHIN REASONABLE LIMITATIONS.
- (10.) THAT BUREAU, INSTITUTIONAL AND DIVISIONAL DIRECTORS BE GIVEN DEFINITE APPOINTMENTS WITH THE DIRECTOR OF PUBLIC HEALTH AND THE BUSINESS MANAGER TO DISCUSS BUDGET REQUESTS.
- (11.) THAT BUREAU, INSTITUTIONAL AND DIVISIONAL DIRECTORS BE INVITED TO ATTEND BUDGET HEARINGS WITH THE CHIEF ADMINISTRATIVE OFFICER, THE MAYOR, AND THE FINANCE COMMITTEE OF THE COUNTY BOARD OF SUPERVISORS WHEN THEIR PRESENCE WOULD BE HELPFUL IN CLARIFYING THE BASIC REASONS FOR SPECIFIC REQUESTS.

While there is provision for a Board of Health, the Board has not functioned for a number of years.

A carefully selected Advisory Board of Health can be invaluable to both the Director of Public Health and to the Chief Administrative Officer.

It is strongly recommended:-

- (12.) THAT THE CHIEF ADMINISTRATIVE OFFICER APPOINT A BOARD OF HEALTH AND PROVIDE THAT SUCH BOARD HOLD REGULARLY SCHEDULED MONTHLY MEETINGS. THE BOARD MAY MEET AT SUCH OTHER TIMES AS EITHER THE DIRECTOR OF PUBLIC HEALTH OR THE CHAIRMAN OF THE BOARD MAY DESIGNATE. THE CHAIRMAN OF THE BOARD SHOULD BE ELECTED ANNUALLY BY THE MEMBERS OF THE BOARD.
- (13.) THAT THE BOARD OF HEALTH BE COMPOSED OF FIVE MEMBERS, TWO OF WHOM SHOULD BE PHYSICIANS AND THREE FROM OTHER WALKS OF LIFE. APPOINTMENTS SHOULD BE FOR FIVE YEAR STAGGERED TERMS OF OFFICE SO APPOINTED AS TO MAKE ONE MEMBER'S TERM EXPIRE EACH YEAR. MEMBERS WHOSE TERMS EXPIRE MAY BE RE-APPOINTED OR REPLACED AT THE DISCRETION OF THE CHIEF ADMINISTRATIVE OFFICER.
- (14.) THAT THE BOARD OF HEALTH BE AN ADVISORY, CONSULTATIVE, JUDICIARY, BUT NOT AN EXECUTIVE BODY.
- (15.) THAT THE BOARD OF HEALTH HAVE THE RIGHT, UPON THE RECOMMENDATION OF THE DIRECTOR OF PUBLIC HEALTH OR OF THE CHIEF ADMINISTRATIVE OFFICER, TO PASS SUCH RULES AND REGULATIONS AS IT DEEMS NECESSARY FOR THE PROTECTION AND PROMOTION OF THE PUBLIC HEALTH. SUCH RULES AND REGULATIONS MUST NOT BE IN CONFLICT WITH EXISTING LEGISLATION, EITHER

- (15.) STATE OR LOCAL, NOR IN CONFLICT WITH RULES AND
Cont. REGULATIONS OF THE STATE BOARD OF HEALTH. RULES
AND REGULATIONS ADOPTED BY THE SAN FRANCISCO
BOARD OF HEALTH MAY BE MORE STRINGENT BUT NOT LESS
STRINGENT THAN EXISTING LEGISLATION OR RULES AND
REGULATIONS OF THE STATE BOARD OF HEALTH.
- (16.) THAT THE DIRECTOR OF PUBLIC HEALTH ACT AS SECRETARY
OF THE BOARD OF HEALTH BUT HE SHOULD NOT BE A MEMBER.
- (17.) THAT THE BOARD OF HEALTH MAY HOLD HEARINGS FOR
PERSONS OR EMPLOYEES WITH ALLEGED GRIEVANCES
AGAINST THE DEPARTMENT OF PUBLIC HEALTH AND MAY
MAKE RECOMMENDATIONS CONCERNING SUCH CASES TO THE
DIRECTOR OF PUBLIC HEALTH AND, IF REQUESTED, TO
THE CHIEF ADMINISTRATIVE OFFICER. FINAL DECISIONS
ON SUCH CASES, UNLESS THEY INVOLVE THE NECESSITY
OF A DECISION BY THE CIVIL SERVICE COMMISSION,
SHOULD BE MADE BY THE DIRECTOR OF PUBLIC HEALTH
OR THE CHIEF ADMINISTRATIVE OFFICER.

The importance of a very carefully selected Board of Health composed of important, civic minded people, can hardly be overemphasized.

While, as previously stated, the present Director of Public Health possesses exceptional qualifications for his office, The City Charter provides no real qualifications which would insure the appointment of a qualified director. The Director of Public Health has no assurance of reasonable tenure of office; he serves at the pleasure of the Chief Administrative Officer. Both of these basic weaknesses should be corrected.

It is therefore recommended:-

- (18) THAT NO PERSON SHALL BE ELIGIBLE FOR APPOINTMENT AS DIRECTOR OF PUBLIC HEALTH IN SAN FRANCISCO UNLESS SUCH PERSON HOLDS A DEGREE OF DOCTOR OF MEDICINE FROM AN APPROVED MEDICAL SCHOOL AND IS ELIGIBLE TO LICENSE TO PRACTICE IN THE STATE OF CALIFORNIA. HE MUST HAVE HAD IN ADDITION AT LEAST ONE YEAR'S POST GRADUATE TRAINING IN A RECOGNIZED SCHOOL OF PUBLIC HEALTH AND A MINIMUM OF TWO YEARS' PRACTICAL AND SUCCESSFUL EXPERIENCE AS A FULL-TIME ADMINISTRATIVE OFFICER IN A WELL ORGANIZED HEALTH DEPARTMENT. IN LIEU OF THE POST GRADUATE TRAINING IN A SCHOOL OF PUBLIC HEALTH SUCH PERSON MUST HAVE HAD A MINIMUM OF FIVE YEARS' PRACTICAL AND SUCCESSFUL EXPERIENCE AS A FULL-TIME ADMINISTRATIVE OFFICER IN A WELL ORGANIZED HEALTH DEPARTMENT. RESIDENCE SHOULD NOT BE A PREREQUISITE.

It is further recommended:-

- (19) THAT THE DIRECTOR OF PUBLIC HEALTH BE APPOINTED BY THE CHIEF ADMINISTRATIVE OFFICER UPON THE RECOMMENDATION OF THE BOARD OF HEALTH. THE DIRECTOR SHOULD BE APPOINTED FOR A FIVE YEAR TERM AND MAY BE REAPPOINTED OR SUPPLANTED AT THE DISCRETION OF THE CHIEF ADMINISTRATIVE OFFICER. THE CHIEF ADMINISTRATIVE OFFICER MAY REMOVE THE DIRECTOR OF PUBLIC HEALTH FOR MISCONDUCT,

- (19) INCOMPETENCY, OR NEGLECT OF DUTY, AFTER AN
(Cont.) OPPORTUNITY TO BE HEARD ON WRITTEN CHARGES.

Since, at present, full-time physicians employed by the city are not adequately protected against possible damage or malpractice suits, it is recommended:-

- (20) THAT THE CITY AND COUNTY OF SAN FRANCISCO PROVIDES ADEQUATE PROTECTION AND INSURANCE AGAINST POSSIBLE DAMAGE OR MALPRACTICE SUITS FOR ALL PHYSICIANS WHOM IT EMPLOYS ON A FULL-TIME BASIS.
- (21) THAT THE SALARY OF THE ASSISTANT DIRECTOR OF PUBLIC HEALTH BE INCREASED TO FROM \$500. - \$700. AND THAT THIS POSITION BE AN APPOINTMENT OF THE DIRECTOR OF PUBLIC HEALTH (NON CIVIL SERVICE).
- (22) THAT A SECOND POSITION OF ASSISTANT DIRECTOR OF PUBLIC HEALTH (TO HAVE SUPERVISION OVER INSTITUTIONS) BE ESTABLISHED WITH A SALARY OF FROM \$500. - \$700. AND THAT THIS POSITION BE AN APPOINTMENT BY THE DIRECTOR OF PUBLIC HEALTH (NON CIVIL SERVICE).
- (23) THAT A WELL TRAINED PUBLIC HEALTH ENGINEER BE APPOINTED AS THE DIRECTOR OF THE SECTION ON ENVIRONMENTAL SANITATION AND TO GIVE PUBLIC HEALTH ENGINEERING SERVICE TO THE ENTIRE DEPARTMENT OF PUBLIC HEALTH.

(24.) THAT A BUREAU OF HEALTH EDUCATION BE ESTABLISHED AS A FUNDAMENTAL NECESSITY OF ANY EFFECTIVE PROGRAM OF HEALTH CONSERVATION AND PROMOTION

(25.) THAT A BUREAU OF STATISTICS AND RECORDS BE ESTABLISHED AND BE DIRECTED BY A PERSON WITH BOTH PUBLIC HEALTH AND STATISTICAL TRAINING.

This is partially new.

(26.) THAT A BUREAU OF MENTAL HEALTH BE CREATED TO ABSORB AND BROADEN THE FUNCTIONS NOW CARRIED ON IN THIS FIELD BY THE BUREAUS OF CHILD HYGIENE AND VENEREAL DISEASE CONTROL.

This is largely new and probably can not be developed until near the close of the war.

(27.) THAT A BUREAU OF ADULT HEALTH INCLUDING INDUSTRIAL HYGIENE BE ESTABLISHED AS SOON AS POSSIBLE.

This is new and will have to wait until the manpower shortage is eased.

(28.) THAT A WELL TRAINED NUTRITIONIST BE ADDED TO THE STAFF OF THE BUREAU OF MATERNAL AND CHILD HEALTH (NOW DESIGNATED AS THE BUREAU OF CHILD HYGIENE) AS A VERY IMPORTANT NEED OF THE DEPARTMENT.

(29.) THAT PUBLIC HEALTH NURSING SALARIES BE INCREASED AS FOLLOWS:

- (a) PUBLIC HEALTH NURSES TO, FROM \$175. - \$225.
- (b) SUPERVISORS OF PUBLIC HEALTH NURSING TO, FROM \$225. - \$275.

(29) (c) ASSISTANT DIRECTOR OF PUBLIC HEALTH
(Cont.) NURSING TO, FROM \$280. - \$350.

(d) DIRECTOR OF PUBLIC HEALTH NURSING TO,
FROM \$400. - \$500.

The salary of the personnel director is not in keeping with the duties and responsibilities of the position.

It is recommended:-

(30) THAT THE SALARY OF THE PERSONNEL OFFICER
BE INCREASED TO, FROM \$350. - \$450.

While this public health study can not and should not include a thorough going study of Civil Service, the administration of the Department of Public Health is so greatly affected by Civil Service that one can not ignore the questions which inevitably arise in connection therewith. In the section on Weaknesses attention was called to a number of instances in which Civil Service practices and decisions affected adversely the Department of Public Health.

In order to correct these weaknesses, it is recommended:-

(31) THAT PERSONS WITH MORE THAN THE MINIMUM
QUALIFICATIONS FOR A GIVEN POSITION BE
EMPLOYED AT MORE THAN THE MINIMUM SALARY

It is not suggested that this be a blanket authorization. All cases falling within this category should be considered, by the Department of Public Health and the Civil Service Commission, on their individual merits. In the case of a person with exceptional qualifications, permission should be granted to employ such person at the maximum salary.

(32) THAT PERSONS SHOULD NOT BE GIVEN INCREMENTAL
SALARY INCREASES UNLESS THEY HAVE DEMONSTRATED
ABILITY WHICH JUSTIFIES SUCH INCREASE.

- (33) THAT ANY PERSON WHO HAS DEMONSTRATED EXCEPTIONAL ABILITY BE PERMITTED, UPON THE RECOMMENDATION OF HIS OR HER IMMEDIATE SUPERIOR AND THE APPROVAL OF THE DIRECTOR OR ASSISTANT DIRECTOR OF PUBLIC HEALTH AND THE CIVIL SERVICE COMMISSION, TO RECEIVE A SALARY ABOVE THAT OF THE NEXT INCREMENTAL INCREASE.

The two preceding recommendations are obviously based on the premise that some persons are not entitled to increases simply because they have put in a certain amount of time while others are entitled, because of their initiative and demonstrated ability, to more than the minimum incremental increase.

- (34) THAT IN EMPLOYING NEW PERSONNEL PREFERENCE SHOULD BE GIVEN TO SAN FRANCISCO RESIDENTS BUT IF PROPERLY QUALIFIED RESIDENTS CAN NOT BE SECURED RESIDENCE REQUIREMENTS SHOULD BE WAIVED.

Civil Service should consider cases on their individual merits. For example, in the case of key administrative positions, if a San Francisco resident just meets the minimum qualifications for the key administrative position in question, but a person, living somewhere outside of San Francisco or even in another state, possesses superior qualifications of training and experience, the resident requirement should be waived in the interest of better service.

- (35) THAT CIVIL SERVICE REVISE ITS QUALIFICATION REQUIREMENTS AND EXAMINATIONS FOR VARIOUS PROFESSIONAL AND TECHNICAL POSITIONS SO AS TO INSURE THE RECRUITMENT OF QUALIFIED PERSONS FOR SUCH POSITIONS.

It is further recommended:-

- (36) THAT THE MAYOR AUTHORIZE AND INITIATE A COMPLETE AND THOROUGH STUDY OF THE CIVIL SERVICE COMMISSION AND ITS SERVICES IN SAN FRANCISCO.
- (37) THAT A TUBERCULOSIS CONTROLLER BE APPOINTED, TO HAVE SUPERVISION OVER THE ENTIRE TUBERCULOSIS CONTROL PROGRAM, INCLUDING PLANNING AND COORDINATION, EPIDEMIOLOGY, CASE FINDING, CASE HOLDING AND FOLLOW-UP. THAT HE ALSO BE RESPONSIBLE FOR ALL ADMISSIONS, TRANSFERS AND DISCHARGES TO AND FROM ALL PUBLIC TUBERCULOSIS INSTITUTIONS. THAT SUCH PERSON BE A PHYSICIAN WITH SUPERIOR TRAINING AND EXPERIENCE IN TUBERCULOSIS, PARTICULARLY THE PUBLIC HEALTH ASPECTS OF THE DISEASE.
- (38) THAT THE HOSPITALIZATION OF ACTIVE CASES OF TUBERCULOSIS BE INSISTED ON AS THE BASIC ESSENTIAL OF ANY EFFECTIVE PROGRAM FOR CONTROLLING TUBERCULOSIS.
- (39) THAT THE CHILDREN'S SERVICE AT THE TUBERCULOSIS UNIT OF THE SAN FRANCISCO HOSPITAL BE DISCONTINUED, EXCEPT FOR THE VERY OCCASIONAL CHILD WHOSE PROGNOSIS IS POOR, AND THAT ADULT TYPE

(39) CASES, THOSE WITH BONE AND JOINT INVOLVEMENTS,
(Cont.) AND THOSE WITH PRIMARY INFECTIONS WHICH SEEM
DESTINED TO PROGRESS TO THE ADULT TYPE BE TRANS-
FERRED TO THE HASSLER HEALTH HOME (NOT THE
CHILDREN'S BUILDING).

Childhood type or primary infections, with the exception noted in the recommendation, should be transferred to their homes or to some institution other than an institution for the care of adult type tuberculosis.

(40) THAT EVERY EFFORT BE MADE TO TRANSFER ALL, OR AS NEARLY AS POSSIBLE ALL, TUBERCULOSIS CASES NOW AT THE SAN FRANCISCO TUBERCULOSIS UNIT TO THE HASSLER HEALTH HOME, EXCEPT (a) MORIBUND CASES, (b) CASES NEEDING TUBERCULOSIS SURGERY WHICH CAN NOT BE PROVIDED AT HASSLER, AND (c) CASES NEEDING OTHER MEDICAL OR SURGICAL CARE NOT OBTAINABLE AT HASSLER.

(41) THAT NO CHANGES, IN THE PLAN OF ADMINISTERING THE SERVICES OF THE SAN FRANCISCO HOSPITAL, SHOULD BE MADE WHICH WOULD SERIOUSLY INTERFERE WITH THE BASICALLY IMPORTANT MEDICAL CARE AND MEDICAL EDUCATIONAL FUNCTIONS OF THE INSTITUTION.

The present superintendent of the San Francisco Hospital is being employed on a limited tenure basis in spite of his having occupied that position for nearly two years.

It is recommended:-

(42) THAT THE POSITION OF SUPERINTENDENT OF THE SAN

- (42) FRANCISCO HOSPITAL BE PLACED AS SOON AS POSSIBLE
(Cont.)
ON A PERMANENT BASIS.

The person who is carrying on the business administrative studies at the San Francisco Hospital, which have already resulted in substantial economies and seem likely to produce still further savings, (see section on Strengths) is at present classified as a senior bookkeeper at a salary which is not at all commensurate with his contribution to the service.

It is therefore recommended:-

- (43) THAT THE POSITION AT THE SAN FRANCISCO HOSPITAL NOW CLASSIFIED AS SENIOR BOOKKEEPER BE CHANGED TO THAT OF ASSISTANT SUPERINTENDENT ADMINISTRATIVE WITH A SALARY OF, FROM \$350. - \$450.
- (44) THAT SOCIAL SERVICE BY THE SOCIAL SERVICE DIVISION OF THE SAN FRANCISCO HOSPITAL BE ELIMINATED FOR TUBERCULOSIS AND THE ACUTE COMMUNICABLE DISEASES EXCEPT TO DETERMINE THE RESIDENTIAL AND JURISDICTIONAL (VETERANS ADMINISTRATION OR OTHER AGENCY), NOT FINANCIAL, ELIGIBILITY OF THE PATIENT.
- (45) THAT EVERY POSSIBLE EFFORT BE MADE TO OPEN AT LEAST TWO ADDITIONAL INFIRMARY WARDS AT THE LAGUNA HONDA HOME AS A NECESSARY METHOD OF PREVENTING THE "BOTTLE NECK" OCCASIONED BY THE LARGE NUMBER OF PATIENTS OCCUPYING ACUTE HOSPITAL BEDS AT THE SAN FRANCISCO HOSPITAL WHO SHOULD BE AT LAGUNA HONDA.

(46) THAT THE SOCIAL SERVICE DIVISION AT THE SAN FRANCISCO HOSPITAL, EXCEPT IN VERY RARE INSTANCES, STOP ADMITTING PATIENTS TO THE INFIRMARY AT LAGUNA HONDA UNTIL THE MAJORITY OF LAGUNA HONDA PATIENTS (ON FEB. 1, 1945 THERE WERE 162), NOW OCCUPYING ACUTE HOSPITAL BEDS AT SAN FRANCISCO, HAVE BEEN TRANSFERRED TO THAT INSTITUTION.

(47) THAT HOUSING FACILITIES AT THE LAGUNA HONDA HOME NOT BEING USED BE MADE AVAILABLE TO SOME RESPONSIBLE NON-PROFIT ORGANIZATION FOR THE CARE OF CONVALESCENTS, WITH THE UNDERSTANDING THAT SUCH ORGANIZATION WILL ASSUME THE ENTIRE RESPONSIBILITY FOR RUNNING THE SERVICE, INCLUDING STAFFING AND MAINTENANCE.

(48) THAT AT THE END OF THE WAR, BUT NOT BEFORE, THE PARK AND ALEMANY EMERGENCY HOSPITALS BE CLOSED BUT THAT AMBULANCE SERVICE FOR THESE DISTRICTS BE PROVIDED THROUGH THE CENTRAL AND MISSION EMERGENCY HOSPITALS.

As a means of improving the Emergency Hospital Service, it is recommended:-

(49) THAT EACH AMBULANCE CREW BE COMPOSED OF TWO MEDICAL STEWARDS (NOW CALLED STEWARDS), ONE OF WHOM SHALL BE QUALIFIED AS A CHAUFFEUR, INSTEAD OF, AS AT PRESENT, AN AMBULANCE DRIVER AND A STEWARD.

As a means of developing a confidence on the part of sick or injured persons, who may need emergency service, in the persons who are to give that service and who have passed qualifying examinations to render the service, it is recommended:-

(50) THAT THE TITLE OF STEWARD BE CHANGED TO
MEDICAL STEWARD.

(51) THAT THE CHILDREN'S BUILDING AT THE HASSLER
HEALTH HOME BE MADE AVAILABLE TO THE STATE
DEPARTMENT OF PUBLIC HEALTH AND THE HEART
COMMITTEE OF THE SAN FRANCISCO TUBERCULOSIS
ASSOCIATION FOR THE CARE OF CHILDREN WITH
RHEUMATIC FEVER, WITH THE UNDERSTANDING THAT
THESE ORGANIZATIONS WILL ASSUME THE ENTIRE
RESPONSIBILITY FOR THE SERVICE, INCLUDING
STAFFING AND MAINTENANCE.

If at the end of two or three years this program proves
successful, the City should give serious consideration to taking
it over.

HEALTH CONSERVATION

The Health Conservation Branch of the San Francisco Department of Public Health (now roughly referred to as the "Central Office") would consist, in accordance with the proposed plan of organization, of an Assistant Director of Public Health and the three major sections of General Services, Preventive Medical Services, and Environmental Sanitation. The Assistant Director of Public Health should be a non-civil service position and residence should not be a prerequisite.

GENERAL SERVICES

The section of General Services would include the Bureaus of Administration, Statistics and Records (partially new), Laboratories (partially new), and Health Education (new).

ADMINISTRATION

The present Bureau of Administration consists of the Business Manager, the Personnel Officer, an accountant, 4 bookkeepers, 3 clerk-stenographers, 9 clerks, 2 telephone operators, a messenger, an elevator operator, and a chauffeur, making a total of 24. This total is exclusive of the Director and the Assistant Director of Public Health.

The total 1944 - 1945 appropriations for the activities carried on by the personnel just enumerated, including the Director and Assistant Director, were \$146,725.00. This amount obviously includes not only services performed in relation to the Central Office or Health Conservation but also administrative services for the entire department, including institutions. By ascertaining the approximate amount of time and service given to the several major activities of the department, it has been estimated that about 48.5 per cent of service and therefore cost is chargeable to Health Conservation, 32.9 per cent to the San Francisco Hospital, 9.0 per cent to the Laguna Honda Home, 5.2 per cent to the Emergency Hospital Service, and 4.4 per cent to the Hassler Health Home. (See Table 7.)

On this basis, appropriations for administration as applied to Health Conservation total \$71,096.00.

All activities relating to business administration, including accounting, bookkeeping, employment, personnel, and purchasing function through this bureau.

The Bureau is reasonably adequately staffed and is capably administered by the Business Manager. No major changes in this Bureau seem necessary.

As previously stated, the Personnel Officer is not paid a salary commensurate with the duties and responsibilities of his position. The Personnel Officer is responsible for from 1500 to 2000 employees involving more than 60 different categories. The complexity and importance of this position warrants more adequate remuneration. It is therefore recommended:-

- (1) THAT THE SALARY OF THE PERSONNEL OFFICER OF
THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
BE INCREASED TO, FROM \$350. - \$450.

STATISTICS AND RECORDS

At present there is no Bureau of Statistics and Records. Activities related to Birth Registration, Death Registration, and Statistics (the processing and analysis of birth and death records, morbidity reports and certain records of the hospital services) are carried on separately. Those in charge are responsible directly to the Director of Public Health. Service records (that is, records of services performed by public health nurses, clinic records, and services of physicians in child hygiene, tuberculosis control, epidemiology, etc.) are kept and analyzed (in so far as they are kept and analyzed) in the several bureaus to which the records apply.

Birth Registration has a total of 5 persons, including a chief, 1 clerk-stenographer, and 3 clerks. Death Registration has 3 persons, including a chief, a clerk-stenographer, and a clerk. Statistics has a Director, a statistician, and a clerk-stenographer, a total of 3. This makes a total of 11 persons in the three activities.

Appropriations for these three activities, Birth and Death Registration and Statistics, for the fiscal year 1944-1945, totalled \$29,100.00, or 3.7 cents per capita. Income for these functions (for the past fiscal year) totalled \$38,416.00, or \$9, 316.00 more than anticipated expenditures for the present fiscal year. While Income goes back into general funds of the city, this, nevertheless, means that these activities in terms of tax funds not only do not cost the city anything but actually produce a revenue of something over \$9,000.00 for the city.

The setting up and keeping of records which serve no

truly useful purpose can be and often are very time-consuming and therefore expensive. On the other hand, statistics and records which are carefully developed, analyzed and interpreted are of tremendous value to any health department. The importance of analyzing vital statistics (birth, death, and deaths from certain causes), and sickness records side by side with service records (records of services designed to meet the health problems which have been defined by vital statistics and morbidity records) can hardly be overemphasized. Such a coordinated planning and use of records constitute the fundamental basis for (a) defining health problems, (b) measuring progress or lack of progress in meeting those problems, and (c) program planning.

While the routine work of birth and death registration and of processing such statistics as are sent to the Statistical Division is carried on satisfactorily, there is at present no coordinated planning and use of records and the Department possesses no mechanical tabulating equipment. In a department as big as the San Francisco Department of Public Health there are sufficient records worth tabulating to justify the use of mechanical tabulating machinery.

At present, Birth Registration, Death Registration, and Statistics are housed on separate floors. A closer association of these activities, both in administration and housing, is clearly indicated. If housed together there could be far more flexibility in the use of clerical staff than is now possible. The present method of typing copies of birth and death certificates is not only time-consuming but is subject to errors in interpreting the writing on the original certificate on the part of the person doing the copying. A small photostat machine in the Bureau would not only be time-saving but would eliminate any possible errors of interpretation. While birth and death certificates are stored in steel cabinets, these do not afford the degree of protection which would be provided by a fire-proof vault.

As a necessary means of providing a scientific basis for program planning and of measuring progress in meeting health problems, it is recommended:-

- (1) THAT A BUREAU OF STATISTICS AND RECORDS BE ESTABLISHED AND BE DIRECTED BY A PERSON WITH BOTH PUBLIC HEALTH AND STATISTICAL TRAINING.
- (2) THAT THE FUNCTIONS OF THE BUREAU OF STATISTICS AND RECORDS INCLUDE THE TABULATION AND ANALYSIS

(2) OF ALL STATISTICS AND RECORDS OF THE ENTIRE
(Cont.) DEPARTMENT, NOT ONLY VITAL STATISTICS BUT
MORBIDITY RECORDS, SERVICE RECORDS OF ALL
BUREAUS AND DIVISIONS, AND RECORDS RECEIVED
BY THE DEPARTMENT FROM OTHER SOURCES.

This recommendation is not intended to prevent bureaus or divisions from setting up analyses which they may desire and need. Such analyses, however, should be planned in consultation with the Director of the Bureau of Statistics and Records.

The interpretation of specific records calls for conferences between the Bureau of Statistics and Records and the Bureau or Division to which the records apply.

Sufficient personnel to assure the prompt return of analyzed records, obviously, is essential.

(3) THAT NO RECORD FORMS IN ANY BUREAU OR DIVISION BE
PRINTED OR USED UNTIL THEY HAVE BEEN REVIEWED AND
APPROVED BY THE BUREAU OF STATISTICS AND RECORDS.

The individual Bureau or Division director naturally will indicate what information is needed. The Director of the Bureau of Statistics and Records can assist in the arrangement of the record forms so as to facilitate tabulation and analysis and it should be his prerogative to question the usefulness of each item which is proposed as part of the form.

(4) THAT THE DEPARTMENT OF PUBLIC HEALTH PURCHASE
OR RENT MACHINE TABULATING EQUIPMENT AS A
MORE ECONOMIC, RAPID AND EFFECTIVE METHOD OF
ANALYZING STATISTICS AND RECORDS.

(5) THAT A SMALL PHOTOSTAT MACHINE BE PURCHASED AND
PLACED IN THE BUREAU OF STATISTICS AND RECORDS
AS A MEANS OF FACILITATING THE COPYING OF BIRTH

(5) AND DEATH RECORDS AND OF AVOIDING THE POSSIBLE
(Cont.)

ERRORS WHICH ARE INHERENT IN PERSONAL COPYING.

Health records are not only a source of information for the public health authorities, but also a source of information for the individual. It is a source of information for the individual because it is a record of his own health and of the health of his family.

It would not be fair to say that the health records are a source of information for the public health authorities only. They are a source of information for the individual as well. The individual can see his own health record and can see the health record of his family. This is a source of information for the individual because it is a record of his own health and of the health of his family. It is a source of information for the individual because it is a record of his own health and of the health of his family.

There have been many efforts to make health records more useful to the individual. These efforts have been made through the use of health records in the home, through the use of health records in the school, and through the use of health records in the community. These efforts have been made through the use of health records in the home, through the use of health records in the school, and through the use of health records in the community.

The Department of Health in the State of California has been working to make health records more useful to the individual. It has been working to make health records more useful to the individual by making them more accessible to the individual. It has been working to make health records more useful to the individual by making them more accessible to the individual. It has been working to make health records more useful to the individual by making them more accessible to the individual. It has been working to make health records more useful to the individual by making them more accessible to the individual.

As the State of California has been working to make health records more useful to the individual, it has been working to make health records more useful to the individual by making them more accessible to the individual. It has been working to make health records more useful to the individual by making them more accessible to the individual. It has been working to make health records more useful to the individual by making them more accessible to the individual. It has been working to make health records more useful to the individual by making them more accessible to the individual.

The Health Council, the Social Systems Commission, and the Tuberculosis Association, including the West Coast Tuberculosis Association, are all working to make health records more useful to the individual. They are all working to make health records more useful to the individual by making them more accessible to the individual. They are all working to make health records more useful to the individual by making them more accessible to the individual.

HEALTH EDUCATION

The Department of Health does not have a Bureau of Health Education or any person with special training as a general health educator. There is a health educator in venereal diseases but this is, of course, a specialized service.

It would not be fair or true to say that the Department had done no health educational work except in the field of venereal disease control. The Department, of course, has done a good deal of personal health education through its personnel, particularly public health nurses and physicians in the well child health conferences. This type of individual health education can be and often is extremely valuable but is obviously limited, or largely so, to the number of individuals who can be reached in this manner.

There have also been some efforts in mass health education through lectures, the radio, pamphlet distribution, and newspaper articles. An excellent series of newspaper articles on public health is at present being published.

The Department of Public Health and Preventive Medicine at Stanford is making effective use of Department of Health facilities in teaching undergraduate medical students. The student's field trips are carefully planned and supervised and integrated into the university teaching program. As a means of bringing about a better understanding and appreciation of public health objectives and facilities by the physician of tomorrow, the importance of this type of coordinated program can hardly be overestimated. As physicians continue to increase the practice of preventive medicine there will be a corresponding decrease in sickness and sickness costs. When the Department of Health has developed a real Bureau of Health Education, it seems probable that this service can be still further improved.

As time goes on it is to be hoped that the facilities of the San Francisco Health Department can be used advantageously by the California School of Public Health. Here again, the establishment of a Bureau of Health Education would enhance the opportunity for effective working relationships between the School of Public Health and the Department of Health.

The Health Council, the Social Hygiene Association and the Tuberculosis Association, including the Heart Committee, are all carrying on effective segments of health education.

It is very gratifying to learn that the Board of Education is contemplating the establishment of a Division of Health Education in the Department of Education.

One seems justified in concluding that, while some excellent health education, in certain special fields, is being carried on in San Francisco, there is no continuity of planning or coordination of programs. It is also probably safe to say that programs have hardly begun to tap the potential interest of community organizations, groups, and individuals. Health education in San Francisco may be characterized as good but spasmodic and spotty; too frequently confusing publicity with sound educational objectives. Nearly all people whether as individuals or members of groups, have a real or potential interest in health, but comparatively few have been stimulated to the point of actually doing anything about health.

It should be borne in mind that the direct services of a health department, except in very poor communities, reach but a small proportion of the population. This is doubtless as it should be, but the ultimate objective of a community public health program is that all people should understand and practice established procedures for health protection and health promotion. If we accept this premise, and it is generally accepted, then health education becomes the very backbone of health progress.

In the long run, public health progress depends upon three major factors:-

(a) A sufficient number of professional people (principally physicians, dentists and nurses) who are willing and trained to give adequate preventive medical, dental and health protection and health promotion services to all the people.

(b) A universal understanding on the part of the people of the community of what health protection and health promotion services they can and should have for themselves and their families; an understanding and appreciation sufficiently strong to motivate them to seek the services from those professionally trained to render them.

(c) Adequate protection of those environmental factors over which the individual has little or no control, such as water supply, sewage disposal, housing including plumbing, and milk, meat and other foods and food products.

The preventive or health protection aspects of professional education (particularly of physicians and, to a lesser extent, of dentists and nurses) have improved greatly in the past few years. Still further improvement is indicated but progress is being made.

While continued service and vigilance are necessary and while further improvements can and should be made, on the whole, the environmental factors of health protection (with the exception of some housing areas) are being reasonably well provided.

The greatest failure - and therefore the greatest need - is in providing health education or health information for the people as a whole. What is needed is an educational program of such coverage and of such content as will result in the majority of people accepting and seeking those health protection and health promotion services which they need and ought to have for themselves and their families.

Health educational programs in most communities, including San Francisco, have not put enough emphasis on stimulating and aiding organizations and groups to carry on their own programs. A well known health educator has said: "Doing things for people is often easy but it is often expensive and of temporary benefit. Showing people how to do things for themselves may take a little more time but it is relatively inexpensive and its results are lasting."

The modern well trained health educator would not be expected to spend the majority of his or her time writing articles or making speeches, but, rather, in contacting and stimulating leaders and members of various community groups and organizations to carry on their own programs. The philosophy of the health educator is precisely the antithesis of the all too frequent "big I am and the little you" approaches of the past. The modern, trained health educator stands in the background and stimulates, guides, furnishes information and materials, and assists or arranges for assistance in interpretation, but does not dominate the program.

In stimulating and aiding individuals and groups to organize and pursue their own health educational programs, particularly if these individuals and groups are largely non-professional persons with their primary interests in other fields, four basic principles should be borne in mind:-

(1) The subject, or subjects, for study or development must be of sufficient scope and importance to warrant sustained interest. Obviously, the subject must be presented in a manner that will develop interest.

(2) There must be active individual participation in the study or development of plans.

(3) If the subject or plan involves professional opinion or guidance, there should be a professionally qualified person

to interpret and lend assistance to the study or plan but not to dominate it.

(4) The study or plan should develop definite steps for the solution of the problem or problems involved.

Close working relationships with the Department of Education are essential. Education in health matters is as important with adults as with children and the professional educational techniques are similar. There should be no break in the continuous effort of both the School Department and the Health Department in teaching individuals and groups what to think and do concerning their health promotion and protection. The Directors of Health Education in both the School and Health Departments must integrate their programs and work in closest cooperation. Success in this field will aid materially in developing optimum health and will bring permanent improvement in health behavior, thus preventing costly curative care in the future.

In order to make possible a continuous, well planned and coordinated program of health education, it is strongly recommended:-

- (1) THAT A BUREAU OF HEALTH EDUCATION BE ESTABLISHED WITH AN ESPECIALLY WELL TRAINED HEALTH EDUCATOR AS ITS DIRECTOR, PAID A SALARY COMMENSURATE WITH THE TRAINING AND EXPERIENCE OF THE PERSON SECURED AND THE RESPONSIBILITIES OF THE POSITION.

LABORATORIES

There are two laboratories, one bacteriological, one chemical, separately housed (the former at the Department of Health Building, 101 Grove Street, the latter at the San Francisco Hospital), and separately administered. The Chiefs of these two laboratories are responsible directly to the Director of Public Health.

THE BACTERIOLOGICAL LABORATORY

Personnel.

The personnel of the Bacteriological Laboratory consists of a bacteriologist-in-charge, 3 bacteriologists, 1 part-time consulting bacteriologist, 1 bacteriologist doing venereal disease work, charged to the budget of the Division of Venereal Disease Control but paid from Federal funds, 3 technicians, 1 apprentice technician on part time, 2 clerk-typists, and 3 porters, making a total of 14 (equivalent of full time).

The appropriations for this laboratory for 1944-1945 total \$38,269.00.

Activities.

The work includes the examination, for diagnostic purposes, of specimens received from institutions, private physicians, and medical and inspection services of the Department. It also includes examination of water and milk samples and various other types of samples. Serological work is conducted but none for virus diseases.

Approximately 156,000 examinations were made during 1944.

The number of examinations for the major items, together with the number of positives, were as follows:-

	<u>Total Examinations</u>	<u>Approximate Number of Positives</u>
Serology-syphilis	95,600	11,700
Gonorrhea, smears and cultures	17,500	800
Diphtheria- carriers	17,800	129
Tuberculosis- sputum	6,200	1,200
Typhoid and para-typhoid, and dysentery	4,000	116
Milk and milk products- milk equipment	10,600	-
Water - drinking water and swimming pools	2,200	-

The above examinations represent nearly 99 per cent of the 156,000 total made.

Examinations in the field of venereal disease control, including about 32,000 serological tests in surveys of shipyard and dock workers, and Army, Navy, and Merchant Marine personnel, for nearly all pre-natal and pre-marital cases, and for every patient entering San Francisco Hospital, together with gonorrhea smears and cultures, represent about 72 per cent of the total examinations.

The number of 17,800 examinations for diphtheria seems exceptionally large in a city in which only 41 cases of diphtheria occurred. Contributing to this large number of specimens is the practice of culturing throats of every patient entering San Francisco Hospital.

An endeavor was made to determine whether this latter practice yielded results justifying the large volume of work entailed, - not only in the examination of the specimens, but in the collecting of and transporting specimens, the preparation of media and the washing of thousands of test tubes.

The only records of positive specimens that were readily obtainable in the laboratory were for the 9-month period from April to December, inclusive. There were 60 positive specimens in this period although the total positives reported for the year were 129.

Of these 60 positive specimens, only 4 were from the San Francisco Hospital, exclusive of the Isolation Building.

For the entire year 1944, a summary report indicated that 19 virulence tests had been made and that 8 were positive. In no instance, however, was a positive virulence test found associated with a specimen from San Francisco Hospital, exclusive of the Isolation Building.

In fact, from the period of March 1, 1942 to December 31, 1944, nearly two years, only 7 virulence tests were made of positive diphtheria specimens from San Francisco Hospital, exclusive of the Isolation Building, with only 2 positive virulence results shown.

In view of this result, it is extremely questionable whether the work involved in culturing, as a routine procedure, some 14,000 patients entering San Francisco Hospital in a year's time, is justified. This number is exclusive of some 700 admitted to the Isolation Building.

The records of this laboratory were not kept in a manner to make essential data readily accessible. Monthly reports had not been summarized in an annual statement. Nor was there evidence that the records had been studied to determine the utility of the examinations. Even changes in the clerical staff which might account for disruption in the record keeping would not seem to warrant the apparent lack of interest in the over-all record picture.

The quarters occupied by the laboratory appear to be ample. The one exception is the limited space for washing of glassware and laboratory equipment.

THE CHEMICAL LABORATORY

The personnel of the Chemical Laboratory totals 4, including the senior food chemist, 2 food chemists, and an assistant food chemist.

The appropriation for 1944-1945 is \$12,915.00.

The quarters on the second floor of the laboratory building at the San Francisco Hospital are commodious.

A wide variety of work is carried on. However, 86 per cent of the examinations is for milk and milk products. The division of samples into the major groupings (year of 1944) was

as follows:-

	<u>Number of Specimens Examined</u>	<u>Percentage</u>	<u>Number</u>	<u>Percentage</u>
Milk	15,728	79.)	17,075	85.7
Cream	938	4.7)		
Ice Cream	246	1.2)		
Half & Half (milk & cream)	163	0.8)		
Miscellaneous	1,427	7.2)	2,256	11.4
Urines	577	2.9)		
Water	252	1.3)		
Stomach Contents	483	2.4)	584	2.9
Toxicology	<u>101</u>	<u>0.5</u>)		
Total	19,915	100.		

The Miscellaneous group includes such items as meat products, coffee, tea and spices, soaps, sprays for fruits and vegetables, alcoholic drinks, candy, woolen, cotton and silk products, canned foods, cheese, preservatives, fish and eggs.

The urine specimens are taken mostly from new hospital employees, and are tested for albumen and sugar.

The examinations of stomach contents and the toxicological examinations are of specimens sent from the Police Department, the Emergency Hospitals, and the S. P. C. A.

Tap water samples are examined for the most part only for alkalinity and turbidity.

Milk products are examined for butter fat and total solids.

All the milk products are examined at the Bacteriological Laboratory at 101 Grove Street and two people from the Chemical Laboratory are assigned there continuously. These two workers thus do 86 per cent of the examinations.

The other two staff members working at the Chemical

Laboratory examined 2840 specimens. This would represent only about 5 examinations per person daily. While the time required for the different types of examinations varies widely, the volume of work done at the Chemical Laboratory seems small.

Both Chemical and Bacteriological Laboratories were moved to the present hospital location in 1917. When the Department Headquarters Building at 101 Grove Street was completed it was planned to house both laboratories there. The Bacteriological Laboratory was moved there in 1941. The Chemical Laboratory, however, was never transferred.

Both laboratories ought to be housed adjacent to each other. This is essential where both bacteriological and chemical examinations are made from the same sample. This is what is now done with the milk samples. Adjacent housing of the two laboratories simplifies unified direction, the common use of certain equipment and supplies, and the interchangeable use of personnel.

The better site, - at the hospital or at Grove Street - is debatable.

There is more room at the hospital, and this includes storage room and space for laboratory animals.

The Bacteriological Laboratory is already located at Grove Street as are the two chemists doing milk analyses. Undoubtedly room could be found there for the balance of the Chemical Laboratory. The site is more centrally located, which is of advantage to inspectors bringing in samples. The light is much better.

The future uses of the headquarters building are a factor in the decision. Some of the floors are already crowded. If present services expand, it would be better to retain the Grove Street Building as a main office clinic and conference building. There would be less disruption for the laboratories to operate away from Grove Street than to split off some office units.

It is recommended:-

- (1) THAT THE TWO LABORATORIES BE COMBINED
INTO A SINGLE BUREAU OF LABORATORIES.

(2) THAT A NEW POSITION OF DIRECTOR OF THE BUREAU OF LABORATORIES BE ESTABLISHED WITH REMUNERATION AT A LEVEL WITH OTHER BUREAU DIRECTORS.

(3) THAT THE LABORATORIES BE HOUSED IN ADJACENT QUARTERS.

This matter of site should be studied in more detail by the Department with consideration of future uses of the headquarters building.

(4) THAT THE PRESENT POLICY OF TAKING ROUTINE CULTURES OF ALL ADMISSIONS TO SAN FRANCISCO HOSPITAL TO DETERMINE THE PRESENCE OF DIPHTHERIA BACILLI BE DISCONTINUED.

(5) THAT THE WORK LOAD AND THE UTILITY OF THE EXAMINATIONS NOW MADE AT BOTH LABORATORIES BE REVIEWED, A MORE ADEQUATE AND ORDERLY SYSTEM OF RECORD KEEPING BE ESTABLISHED, AND THAT RECORDS BE INTERMITTENTLY STUDIED WITH THE OBJECT OF MAKING MOST EFFICIENT USE OF THE LABORATORIES.

PREVENTIVE MEDICAL SERVICES

The Section of Preventive Medical Services would include the Bureau of Disease Control (now called Communicable Diseases) with its Divisions of Epidemiology, Tuberculosis and Venereal Disease; Maternal and Child Health (new title), Public Health Nursing, Public Health Dentistry, Mental Health (new in scope) and Adult Health including Industrial Hygiene (new).

DISEASE CONTROL

This function comes under a Bureau of Communicable Diseases, which has three divisions - Epidemiology, Tuberculosis, and Venereal Diseases.

The Bureau is administered by a part-time director who also serves as Chief of the Division of Epidemiology. At the present time also, he is directly responsible for the tuberculosis control work. The present chief in this position is now, during the war, filling a vacancy as Superintendent of the Hassler Health Home, for tuberculosis. The Division of Venereal Disease Control is in charge of a full-time chief.

DIVISION OF EPIDEMIOLOGY

Personnel.

Besides the Bureau Director, serving also as Chief of the Division of Epidemiology, there are in this division 6 epidemiologists (part-time), 1 supervising public health nurse assigned from the Bureau of Public Health Nursing, and 4 clerical people, one of whom gives half time to the Division.*

The Appropriation for epidemiology for 1944-1945 totals \$50,320.00, or 6.5 cents per capita. This amount, however, includes the salaries of 8 "rodent control" men who do not work for the Department but are assigned to the U. S. Public Health Service Plague Control Laboratory.

Activities.

The work of the Division is primarily the visiting of homes for diagnosing suspected cases of communicable disease,

*Some inspection and investigation work is also done by a Bacteriological Milk Inspector assigned to this Division.

and, secondarily, for the inspection of hospitals and massage parlors.

Associated with the diagnostic work are the supervision of all active typhoid carriers, who are not permitted to engage in food handling or to care for children; special epidemiological investigations as to sources, contacts and carriers; placarding, quarantining and releasing from quarantine, and instruction of the family, for certain communicable diseases; inquiry of chicken pox cases among adults owing to the possibility of confusion of this disease with smallpox; special investigation of unusual disease prevalence in schools; immunizing and vaccinating in unusual situations.

Inspection services once or twice a year in all hospitals, except military hospitals, cover matters of cleanliness, quality and care of instruments, food and personnel. Special inspections are made of the maternity divisions of hospitals and of clinics and out-patient departments. Annual inspections are made of all massage parlors.

On the basis of these inspections, licenses are issued either by the local or state health departments or both jointly.

All reports of disease and suspected disease are made to this office and from these reports assignments are made to epidemiologists who telephone the office every hour or so daily. Over the week-end this work is handled through the Central Emergency Hospital. While the epidemiologists are on call for the full working day, these positions are regarded as part time as the actual field duties do not take full time during the day. It is estimated that the 6 epidemiologists perform about 1730 man-days of service during the year. On the basis of 8637 visits made in 1943, this would represent an average of 5 to 6 calls daily for each man.

Each epidemiologist spends approximately an hour a day in the office to be available for diagnosis if a suspected case should present himself at the office, and to complete some of their reports.

The time of the supervising nurse, now spent almost entirely in the office, is used largely in answering telephone inquiries on procedures and regulations. It is felt that some of these duties could be taken over by the clerical staff, allowing the supervising nurse more time for field instruction of nurses in communicable disease control.

A question raised is whether or not the Division is over particular in its insistence that certain services be performed by physicians: Could not some of these services be performed by nurses at lesser expense?

To obtain a clearer picture of the work of the epidemiologists, both the source of disease reports and the specific purposes of the home visit were studied. A cross-section sampling of 360 report cards for the completed year 1943 was used. On the basis of this sampling, the sources of disease reports are summarized in Table A.

The data are grouped into what are termed by the Division as "Major Contagion" and "Minor Contagion".

The table may be read in this manner. Referring to the column headed "Scarlet Fever", 66 per cent of all scarlet fever cases reported were from private physicians; 7 per cent were from private physicians who asked for confirmation of the diagnosis from the health department. Seven per cent were reported from hospitals. Seven per cent each had their origin from families and health department nurses; 2 per cent came to light by the cases walking in to the health department asking for diagnosis; 5 per cent were from other sources, such as clinics.

A number of interesting points are disclosed in this table. The first is that by no means do all reports come from private physicians. Only for scarlet fever is this source of report high.

The second point is that, other than scarlet fever, the reports of the remaining four diseases in the grouping of "Major Contagion" came largely from hospitals. In these instances the case is undoubtedly recognized by the private physician when the patient is sent to the hospital but the report based on the final diagnosis reaches the health department from the hospital.

Thirdly, the chief source of the so-called "Minor Contagion" is the health department nurse, who learns of these cases in the course of her calls at the homes of school children absent because of illness, and from her contact with the families registered in the baby health stations. Some of these cases came to the attention of nurses several weeks after the occurrence of the disease. The patient may or may not have been attended by a private physician.

Another point is that the instances of private physicians asking confirmation of diagnoses from the health department are extremely few.

Furthermore, the instances of diagnoses arising from people walking in to the department with suspicious rashes or other symptoms are negligible.

A small number of the "Minor Contagion" cases came to attention through direct calls to the health department from

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TABLE A

Origin of Report of Cases of Diseases

Percentage of Sources for each Disease

Based on Sample Counts for Year 1943.

(As Percentages are expressed in round numbers, the total will not equal one hundred per cent exactly.)

Source	"MAJOR CONTAGION"					"MINOR CONTAGION"				
	Scar. Fever	Diph.	Typ- hoid	Epi. Menin	Polio	Measles	Chick. pox	Mumps	Whp. Cgh.	Ger Meas
Private Physicians	66	17	17	30.	25.	37.	16.	18.	23.	17.
Pri. Phys. asking con- firmation of diagno.	7.	0	0	0	2.	0	0	0	0	0.
Hospitals	7.	83.	83.	60.	62.	3.	0	0	6.	0
Families	7.	0	0	0	2.	9.	5.	16.	8.	10.
Health Dept. Nurses	7.	0	0	0	0	40.	78.	63.	56.	69.
Visiting Nurse Assoc.	0	0	0	0	0	8.	2.	4.	0	0
In person- at office	2.	0	0	0	0	0	0	0	0	0
Other	5.	0	0	0	9.	4.	0	0	8.	3.
Coroner	0	0	0	10.	0	0	0	0	0	0

families who suspect the specific cause from their own experience. These reports are investigated by epidemiologists and officially reported as a specific disease by them. As first knowledge of the case originates with the family, it is so credited.

This sampling is believed to fairly represent the general picture as the cards were drawn from the street file in which cards are classified alphabetically by street names and represent the districts of all diagnosticians. It included all of the cases of diphtheria and typhoid fever reported during the Year 1943.

The same sampling was used to determine the reasons for the home visits made by epidemiologists. In this instance, however, we have translated the results of the sample into visits proportional to all cases reported in the Year 1943. Table B thus shows the estimated visits for different purposes in a year's time.

In computing the visits for "Minor Contagion", owing to the lack of clear-cut information on the card, it has been assumed that visits were made on early cases reported as this is the established policy of the Division. Tabulations were made with the aid of an employee of the Division familiar with the practices and methods of recording data.

The total visits made by epidemiologists for all purposes in 1943 was 8637. The total visits in behalf of the 10 diseases as shown in Table B is estimated to be 7909 on the basis of the sampling. This represents about 92 per cent of all visits made.

Of main interest in this table is that 6352 visits, less the 144 for scarlet fever and 3 for poliomyelitis, or 6205, were primarily for diagnosis of the five so-called "minor" diseases. This is about 72 per cent of all visits made by epidemiologists.

The question to be weighed is whether 72 per cent of the time of epidemiologists, costing about \$21,000.00 (including salaries and travel) is best spent in this manner. Do the visits for the different purposes shown in the table really require a physician or could some of them, at least, be made by some one less trained at a saving in cost?

TABLE B
VISITS BY EPIDEMIOLOGISTS

1943

Estimated from sampling count

Purpose of Visit	"MAJOR CONTAGION"					"MINOR CONTAGION"					Total Visit
	Scar. Fev.	Diph.	Typh. Fev.	Epi. Men.	Polio	Meas. les	Chick. pox	Mumps	Whp. Cgh.	Ger. Meas.	
For Diagnosis at req. of Priv. Phys.	53	0	0	0	0	0	0	0	0	0	56
For Diag. & instruction of suspected cases reported other than by priv. physician *	144	0	0	0	3	965	2060	1420	330	1430	6352
For Placard-ing and In-struction only. Priv. Phys. cases	500	7	1	46	36	0	0	0	0	0	590
For Placard-ing and in-struction Hosp. Cases	53	34	6	92	87	0	0	0	0	0	272
For Instruc-tion only. Priv. Phys. cases	0	0	0	0	0	12	67	0	0	0	89
For Instruc-tion only Hosp. Cases	0	0	0	0	0	12	0	0	0	0	12
For Release of Quaranteed Cases	357	68	8	51	64	0	0	0	0	0	548
Total Visit	1107	109	15	189	193	989	2127	1420	330	1430	7909

*This includes placarding of homes with major contagion.

We may approach this matter by presenting two lists of visits, one that admittedly is a proper medical function, the other containing types of visits that might be made by some one else. These data are taken from Table B.

	<u>Requires Physi- cian's Visit</u>	<u>Visit other than by Physician Adequate</u>
For Diagnosis - at request of private physician	56	
For Diagnosis - and instruction of suspected cases re- ported by other than private physicians		
"Major Contagion"	147	
Measles	965	
Liberal estimate of 10% of chicken pox in adults	206	
Balance of chicken pox		1854
Mumps		1420
Whooping Cough		330
German Measles	1430	
For Placarding and Instruction- Private Physicians' Cases		590
For Placarding and Instruction- Hospitalized Cases		272
For Instruction only- Private Physicians' Cases		79
For Instruction only- Hospitalized Cases		12
For Release- Quarantined Cases		548
Total	2804	5105

The significance of this analysis is in the possible saving in the cost of service and the more justifiable use of professional service.

The present cost of a visit, on the estimated basis of \$29,600.00* for the salaries and travel allowance of epidemiologists, and using the 8637 visits made for all purposes in 1943, is about \$3.40. This may be a trifle high as the visits for institutional inspection have been included, and these visits undoubtedly take more time than the diagnostic visits.

From the above table, 2804 visits would continue to be made by epidemiologists. At \$2.40 per visit this would amount to \$9,500.00.

Of the 5105 visits by others we may deduct those visits now made by epidemiologists, but which had already been made previously by health department nurses at the time they reported the case as suspicious. This deduction would include 1440 visits for chicken pox, 895 for mumps and 185 for whooping cough, or a total of 2520. Subtracting this number from the 5105 would leave 2585.

A recapitulation of cost comparisons would then be as follows:-

Present cost for epidemiologists' salaries and travel \$29,600.

Estimated new cost of visits:

2804 @ \$3.40 \$9,500.
** 728 @ \$.40 2,480. \$11,980.

Visits by nurses 2585 @ 1.80*** 4,660.

Total cost under new proposal 16,640.

Saving \$12,960.

Under this suggested plan there would be a saving of around \$13,000.00.

*We have used the salary of all 6 epidemiologists at \$386. a month, although temporarily, at present, the salary of two city physicians serving as epidemiologists is only \$343. each.

**Difference between 8637 total visits and 7909 in table, representing visits to institutions and for other diseases.

***Estimated at half the salary of epidemiologists and same allowance for travel.

Thus, the number of epidemiologists might be reduced from 6 to 3 and nurses employed to do the work indicated.

The crux of this decision rests on a readiness -

1- to accept as suspected cases, without further verification, the reports emanating from health department nurses, namely, the chicken pox cases in children with evidence of successful vaccination against smallpox and the cases of mumps and whooping cough (where the evidence is quite distinctive);

2- to place in the hands of nurses the placarding of homes and instruction of families of cases already diagnosed by private physicians; and

3- to place in the hands of nurses the release of cases from quarantine.

This is not as revolutionary a proposal as may appear at first reading, for these reasons:

There is little or no indication from an inspection of the report cards that suspected cases of so-called "minor contagion" reported by nurses have been changed to a cause other than what was suspected after being seen by epidemiologists.

Some of the reports of "minor contagion" coming to the attention of health department nurses are received long after their occurrence and are based on what the families tell the nurse. These are accepted in the department office as reported diseases.

Unquestionably, many cases of "minor contagion" are not reported at all.

Judging by the sample studied, it is now the practice to release from quarantine by telephone without a home visit cases first reported by private physicians and hospitals, to the number of 40 per cent of the scarlet fever cases, 22 per cent of the meningitis cases, and 34 per cent of the poliomyelitis cases. In addition, the diphtheria and typhoid cases are released on the basis of laboratory specimens which, seemingly, could perfectly well be taken by nurses.

No visits are now made by epidemiologists for the release from isolation of the 5 diseases grouped under "minor contagion".

These suggestions should be seriously studied and discussed within the Department to determine their practicality.

In making these calculations from the sampling study, we are fully aware that the number of cases of communicable disease, particularly measles, will fluctuate from year to year and that they will cluster in certain periods of the year. The

annual fluctuation would of course alter the cost computations upon which the present estimates are made. However, these facts would not invalidate the underlying principles involved.

We are also not unmindful of the difficulty of securing public health nurses during the war emergency. Naturally, this circumstance will govern the timing of any of these changes which on closer study would be deemed feasible.

Major Strong Points in the Work of the Division of Epidemiology.

The Division is under a director who has had long experience in this field.

It is as reasonably well staffed as could be expected in the war emergency.

The quarters are ample.

A progressive attitude is displayed in adapting regulations and procedures to changing conditions and increasing knowledge.

Major Weaknesses.

From the standpoint of cost, one of the weaknesses is the use of physicians in certain types of home visits that might equally well be made by nurses.

The report cards of idseases do not show as clearly as they might the source of the eventually reported case, whether the epidemiologist actually visited the case, and whether this diagnosis differed from the suspected cause originally reported.

There is a lack of intimate study from time to time of the records and work done to determine what and how it is actually being done, and to learn whether or not performance is actually in accord with the policies and procedures laid down.

It is recommended:-

- (1) THAT CALLS WHICH ARE NOW BEING MADE BY
EPIDEMIOLOGISTS WHICH COULD BE MADE AS
EFFECTIVELY BY PUBLIC HEALTH NURSES BE
TURNED OVER TO NURSES.

It is estimated that this change would reduce the number of epidemiologists from 6 to 3, with an approximate annual saving of \$13,000.00.

- (2) THAT THE PRESENT PRACTICE OF HAVING EACH EPIDEMIOLOGIST REPORT TO THE OFFICE FOR AN HOUR EACH DAY BE DISCONTINUED AND THAT ALL ROUTINE REPORTS OF THE EPIDEMIOLOGIST (WITH THE EXCEPTION OF REPORTS OF INSTITUTIONAL OR OTHER INSPECTIONS OR SPECIAL INVESTIGATIONAL REPORTS REQUESTED BY THE DIRECTOR OF THE BUREAU) BE MADE BY TELEPHONE.

A triplicating machine would be found very useful in recording and relaying communicable disease calls. The three copies would be distributed as follows:- the original filed in the office, one copy to the Statistical Division, and the third copy to the nurse in whose district the case resides.

In order for the Director of the Bureau to maintain close touch with the epidemiologists it would seem wise to have regular monthly staff meetings.

- (3) THAT WHILE THE EMPLOYMENT OF A DIRECTOR OF THE BUREAU ON PART TIME SERVICE IS JUSTIFIED DURING THE WAR EMERGENCY, EVENTUALLY THIS POSITION, WHICH ALSO COVERS THE CHIEF OF THE DIVISION OF EPIDEMIOLOGY, SHOULD BE ON A FULL TIME BASIS.

- (4) THAT PLACARDING OF HOUSES WITH COMMUNICABLE DISEASES (NOT INSTRUCTION) BE DONE BY MOTOR CYCLE MEN OF THE POLICE DEPARTMENT.

VENEREAL DISEASES

The responsibility for venereal disease control is vested in the Division of Venereal Disease Control. As previously stated, its program is one of the most highly developed and effective in the entire Department of Health.

The personnel of the Division includes the Director and 63 other persons. Since 9 of the physicians are on a half-time basis, the 64 persons give the equivalent of the full-time services of 58-1/3 persons. The table on the next page gives the personnel of the Division, where they work, and from what source they are paid.

The budget of the Division of Venereal Disease Control for 1944-1945, totals \$163,039.00, or 21.0 cents per capita. City-county tax funds total \$86,544.00, or 53.1 per cent of the total, or 11.2 cents per capita; federal and state funds (all but \$2,860.00 are federal funds) total \$72,895.00 and represent 44.7 per cent of the budget and the San Francisco Polyclinic gives \$3,600.00 for venereal disease health education, which represents 2.2 per cent of the budget, or 0.4 cents per capita.

The work of the Venereal Disease Control Division consists of, (a) a diagnostic clinic (for women only) at the Central Office, 101 Grove Street, (b) a large diagnostic and treatment center at 33 Hunt Street, (c) the psychiatric service at 33 Hunt Street, (d) diagnostic and treatment service for the Juvenile Court and for jails, (e) follow-up service for patients and contacts by male investigators and public health nurses, (f) health educational work among various industries and groups, (g) statistical analyses of work done, (h) cooperation with the Women's Court, (i) cooperation with the San Francisco Polyclinic and with the clinics at Stanford and California and at other hospitals, (j) cooperation with the U. S. Marine Hospital, the U. S. Coast Guard and with all Army and Navy posts, and (k) the conduct of blood testing programs in various industries and groups.

The Division of Venereal Disease Control has had splendid backing and support from, and has cooperated effectively with the California Social Hygiene Association, the State Department of Public Health, the Health Council of the Community Chest, the Adult Probation Department, the Police Department, and the armed forces. There have also been effective relationships between the Division and the private practitioners of medicine.

The mere enumeration of its functions impresses one with the scope and complexity of the work of the Division.

PERSONNEL OF THE DIVISION OF VENEREAL DISEASE CONTROL

January, 1945

	Central Office		Diag. Treatment Clinic		Psychiatric Service		Jails or Juv. Court		Source of Payment		
	(1) City	(2) Fed St.	City	Fed St.	City	Fed St.	City	Fed St.	City	Fed St.	TOTAL
Director											1
Physicians			2				$\frac{1}{2}$	$\frac{1}{2}$	$2\frac{1}{2}$	$\frac{1}{2}$	3
Full-time			1(vac)	5	1(3)	1			3	6	9*
Part-time	1										
Sup. P.H. Nur.	1		1						2	0	2
P.H. Nurses	4	1	3						7	1	8
Graduate Nurses			3				1		3	1	4
Health Educator	1								1		1
Psychologists			1			1/3(vac)			1	1/3	1-1/3
Psych. Soc. Workers						2(1 vac)				2	2
Bacteriologists		1		1						2	2
Statisticians		1								1	1
Investigators		4								4	4
Lab. Assistant				1						1	1
Clerk-Stenographers	2	1	2		2				4	3	7
Clerks	$1\frac{1}{2}$	1	1	9					$2\frac{1}{2}$	10	$12\frac{1}{2}$
Orderlies			2						2		2
Porters			2						2		2

There are actually 64 persons in the Division giving the equivalent of the full time services of 58-1/3 persons

- (1) Means paid through the city-County funds.
- (2) Means paid through Federal or State funds.
- (3) A half-time psychiatrist

* These are half-time physicians, thus making the equivalent of 4 1/2 on a full-time basis.

The University of California Clinic has a similar service for the follow-up work on all non-infectious cases. A public health nurse interviews and follows up all patients with chronic diseases. This takes about one fifth of a nurse's time. The clinic furnishes public treatment, with hospitalization, for all patients (if day hospitalization). The clinic also performs all the blood testing for this clinic and also performs blood tests for its semi-infectious patients (those having 720 or less).

The University of California Clinic does its own follow-up on non-infectious cases. A public health nurse interviews and follows up all infectious cases. This takes about one fifth of a nurse's time. The Health Department does the blood testing for all semi-infectious patients.

At the United States Marine Hospital the Health Department furnishes an investigator to interview all patients and to follow up on all infectious cases. This represents about one fifth of an investigator's time. All other cases are given the same service, which takes about one sixth of an investigator's time.

At all Navy and Coast Guard stations the original interviews are carried on by a physician's aide. If they are unable to obtain adequate epidemiologic information, a nurse interview is held by a nurse investigator from the Department of Health. This work occupies about three tenths of the time of an investigator.

Occasional visits are made to hospital clinics which are a small amount of technical assistance work.

Taken together, these services involve the use of slightly less than the full time of one public health nurse and approximately the half time of an investigator.

It should be noted that these services were instituted before the war and should be continued in the post-war period.

The table following (on the next page) gives the public and semi-public facilities for the diagnosis and treatment of venereal diseases in San Francisco.

The manner in which the Division of Venereal Disease Control cooperates with other diagnostic and treatment agencies may be briefly described as follows:-

The San Francisco Polyclinic has its own public health nurse to follow up its cases. A public health nurse from the Venereal Disease Division does the follow-up work on infectious cases. This clinic does its own blood testing. The clinic gives \$3,600.00 annually for venereal disease health education.

The Stanford Clinic has a social worker who does the follow-up work on all non-infectious cases. A Health Department public health nurse interviews and follows up all infectious cases. This takes about one third of a nurse's time. Stanford furnishes rapid treatment, with penicillin, for syphilis patients (8 day hospitalization). The Health Department does all the blood testing for this clinic and also furnishes luetic drugs for its semi-indigent patients (those paying 75¢ or less).

The University of California Clinic does its own follow-up on non-infectious cases. A Health Department public health nurse interviews and follows up all infectious cases. This represents about one fifth of a nurse's time. The Health Department does the blood testing for all semi-indigent patients.

At the United States Marine Hospital the Health Department furnishes an investigator to interview all patients and to follow up on all infectious cases. This represents about one sixth of an investigator's time. All Army posts are given the same service, which takes about one eighth of an investigator's time.

At all Navy and Coast Guard stations the original interviews are carried on by a pharmacist's mate. If they are unable to obtain adequate epidemiologic information, a second interview is held by a male investigator from the Department of Health. This work occupies about three tenths of the time of an investigator.

Occasional visits are made to hospital clinics which do a small amount of venereal disease work.

Taken together, these services involve the use of slightly less than the full time of one public health nurse and approximately the half time of an investigator.

It should be noted that these services were instituted before the war and should be continued in the post-war period.

The table following (on the next page) gives the public and semi-public facilities for the diagnosis and treatment of venereal diseases in San Francisco.

The manner in which the Division of Venereal Diseases Control cooperates with other diagnostic and treatment agencies may be briefly described as follows:

The San Francisco Police Department has its own public health nurse to follow up the cases. A public health nurse from the Venereal Disease Division does the follow-up work on infectious cases. This clinic does its own blood testing. The clinic gives \$3,500.00 annually for venereal disease health education.

The Stanford Clinic has a medical worker who does the follow-up work on all non-infectious cases. A Health Department public health nurse interviews and follows up all infectious cases. This nurse about one fifth of a nurse's time. The Health Department furnishes rapid treatment, with penicillin, for syphilis patients (8 day hospitalization). The Health Department does all the blood testing for this clinic and also furnishes health education for the semi-infectious patients (three days or less).

The University of California Clinic does its own follow-up on non-infectious cases. A Health Department public health nurse interviews and follows up all infectious cases. This nurse sends about one fifth of a nurse's time. The Health Department does the blood testing for all semi-infectious patients.

At the United States Marine Hospital the Health Department furnishes an investigator for the follow-up of all infectious cases. This investigator does the follow-up on all infectious cases. This investigator does the follow-up on an investigator's time. All other patients are given the same service, which takes about one eighth of an investigator's time.

At all Navy and Coast Guard stations the original interviews are carried on by a Health Department nurse. If they are unable to obtain adequate epidemiologic information, a second interview is held by a Health Department nurse from the Department of Health. This work occupies about three fourths of the time of an investigator.

Occasional visits are made to hospital clinics when the small amount of venereal disease work.

When possible, these services involve the use of slightly less than the full time of one public health nurse and approximately the full time of an investigator.

It should be noted that these services were instituted before the war and should be expanded in the post-war period.

PUBLIC AND SEMI-PUBLIC FACILITIES FOR THE DIAGNOSIS
AND TREATMENT OF VENEREAL DISEASES (January, 1945)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Evenings
*H. D. Diagnostic Clinic (Women) 101 Grove Street H. D. Diagnostic & Treat. Clinic 33 Hunt Street		1:00-3:P.M.		1:00-3:P.M.			Mon. & Thurs. 5: - 6:30 P.M.
H.D. Juvenile Court		3 Times a week					
H.D. Women's Jail #3		As necessary					
H.D. S.F. Co. Jail San Bruno		As necessary					
Women's Court Clinic	8:-11:A.M.	8:-11:A.M.	8:-11:A.M.	8:-11:A.M.	8:-11:A.M.	8:-11:A.M.	
Blood Test Surveys	Various industries and groups, including labor unions, in cooperation with the Health Department						
(1) S. F. Polyclinic	8:-9:A.M.						2 nights a wk. 6:30-9:P.M.
(2) Stanford**	2:-5:P.M.	2: -6:P.M.		2:-5:P.M.	2:-5:P.M.		
(3) California	9:-11:A.M.	9:-11:A.M.		9:-11:A.M.	9:-11:A.M.		

(Children's Hospital, St. Mary's Help and St. Lukes all do a small amount of Venereal disease clinic work but do not have special clinics for V.D.)

* Health Department

(1) Charges \$2.00 per visit.

(2) Charges 75¢ to \$1.50 per visit.

(3) Charges 75¢ to \$1.25 per visit.

**Stanford University also furnishes rapid treatment for syphilis.

Space is not available for describing in detail the many ramifications of the venereal disease control program. Suffice it to say that, the program has been carefully and scientifically planned; that it has effectively coordinated the activities of those organizations, groups, and individuals who are interested in the problem; that the area now appears to have, with the exception of the need for a treatment center in the Mission area, reasonably adequate diagnostic and treatment facilities; that organized prostitution has practically disappeared from the area; that the program makes generous use of health educational opportunities; that efforts to obtain information about sex contacts and to find these contacts are being carried on strenuously but are less successful than other phases of the program; and that the psychiatric service is not only unique and extremely interesting but seems to present an exceptionally fruitful approach to not only venereal disease prevention but to the whole field of more effective personal and social adjustment.

The major efforts of the Division fall into perhaps 5 categories:-

1. Diagnosis and treatment.
2. A follow-up effort to (a) obtain the names of sex contacts of venereal disease patients (persons from whom the patient may have contacted the disease or to whom the patient may have given the disease), to find those persons and to have them examined and treated if indicated, and (b) to get lapsed cases back under treatment.
3. Health Education.
4. Blood testing surveys in various industries and groups, including labor unions.
5. Psychiatric service for promiscuous or potentially promiscuous girls.

All of these phases of the work are important, and are well planned and carried out.

In case finding and treatment major emphasis has been placed, as it should be, on finding and keeping under treatment infectious or potentially infectious cases. The effort of the central treatment clinic at 33 Hunt Street has been to confine itself, in so far as possible, to the treatment of infectious or potentially infectious cases and to transfer non-infectious cases (late latent and late cases) to other treatment centers.

Cooperation with other agencies in interviewing and following up infectious cases has already been briefly described. All private physicians reporting infectious cases (primary, secondary, and early latent) are visited by a public health nurse of the Department of Health to determine whether the physician will assume the responsibility for getting the contacts in for examination or whether he wishes the Health Department to do the follow-up work.

Nearly a year ago the method of attempting to have lapsed cases (cases which have missed one or more treatments) return to treatment was altered and improved. The present method is to send a telegram, to all infectious cases which have missed a visit, reading: "Urgent. Report to San Francisco Clinic immediately". The telegram costs 26 cents and has produced excellent results. The telegram frequently reaches a person who can not be found on a personal visit. Apparently it costs about 75 cents to get a case back under treatment by the telegraphic method as compared with a cost of about \$4.50 by personal visits by investigators.

The least effective work in venereal disease control seems to be in (a) ascertaining information from patients concerning from whom they may have contracted the disease and to whom they may have given it, and (b) in finding and examining sex contacts. For example, in 1944 a total of 1253 infectious and potentially infectious cases of syphilis were reported to the Health Department. All of these cases must have contracted the disease from someone and many of them may have given it to others through additional sex contacts. Yet, altogether, these 1253 patients gave information on only 381 sex contacts, which means that less than one of every three patients, on the average, gave any information on where he or she might have contracted the disease or to whom it may have been given. Granted that there are always some patients who won't tell and others who can't tell, nevertheless, this is not a good record. Of the 381 names or addresses of sex contacts which were given, only 157 or 41 per cent were found and examined. If one considers only the cases which were diagnosed and treated by the Health Department, we find that there were 535 cases of infectious or potentially infectious syphilis and that they gave the names or addresses, or both, of 260 sex contacts. Thus, less than one of each two patients gave any information on sex contacts. Of the 260 contacts whose names or addresses were given, the Health Department found and examined 124 or 48 per cent. This record is better but still not as good as it might be. There should be a careful study of methods of interviewing patients to determine why more information is not obtained from patients.

The program of health education is well planned and conducted. The California Social Hygiene Association has not only cooperated with but has assisted substantially in the development of this program. The importance of health education as a basic essential of any effective program of venereal disease

control and prevention is too well recognized to need belaboring in this report.

The woman physician of the Health Department who gives medical service for females under the jurisdiction of the Juvenile Court (for which the Juvenile Court pays the Health Department \$1,800.00) also handles all rape cases. All rape or suspected rape cases are brought to the Central Emergency Hospital and the woman physician is then called from her home to examine the case. Since there is always a physician, and also a nurse, in attendance at the Central Emergency Hospital, there would seem to be no need for calling in another physician.

The psychiatric service, for promiscuous or potentially promiscuous women, carried on in conjunction with the work of the Division of Venereal Disease Control, while not completely new in its overall aspects, is unique in the planning and methodology used here in San Francisco.

The personnel of the psychiatric service consists of the half-time services of a well trained psychiatrist, the part-time service of a psychologist, two trained psychiatric social workers, and two clerk-stenographers, making a total of six. The services of the six persons represent the equivalent of the full-time services of 4-5/6 persons. The cost of the program is approximately \$18,000.00, all paid through United States Public Health Service funds.

A comprehensive and very carefully prepared report (of over 100 pages) has recently been published covering 17 months of the Psychiatric Service (Jan. 1, 1943 to June 1, 1944)*.

Psychiatric service, in relation to venereal disease control, inevitably at this stage in its development and probably for some time to come, includes both research and service. In considering this necessary dual function of research and service two important facts should be borne in mind: (1) there was no previous experience or pattern upon which to develop a program in this field, and (2) the research which is being done is not academic research but, rather, research to determine what types of person or problems, or combination of the two, are most amenable to psychiatric treatment. Criteria for the selection of cases have changed from time to time and are still not completely stabilized. One of the primary objectives of the service was and is to determine what are the underlying factors in promiscuity and what can be done about them. The psychiatric service has classified the several categories into which promiscuous and potentially promiscuous girls fall and has made real progress in determining what types of problems can be most satisfactorily dealt with through

*An Experiment in Psychiatric Treatment of Promiscuous Girls.

psychiatric service. For example, the girl who is habitually promiscuous and is satisfied with the sort of life she is living is not apt to accept or profit by psychiatric service. On the other hand, the girl who is promiscuous because of some dependency need or conflictual feeling is much more likely to accept and profit by psychiatric service.

What have been the results as far as venereal disease control is concerned?

Of the 365 patients who registered with the Psychiatric Service between January 1, 1943 and May 31, 1944, - a total of 17 months - 287 or 78.6 per cent were classified as promiscuous and 78 or 21.4 per cent as apt to become promiscuous. Eighty per cent of the promiscuous group and seventy four per cent of the apt to become promiscuous group were infected with a venereal disease. Only 13 per cent of the promiscuous group and 23 per cent of the apt to become promiscuous group had never been infected.

Of the 365 patients, 15 per cent or 55 accepted and were given Direct Service (comprehensive service); 48 per cent or 175 were given Consultation Service, and 37 per cent or 135 did not receive service. Thus, a total of 230 or 63 per cent accepted and received service. Service was given only on a voluntary basis.

It was possible to follow, for a six month or longer period of time, 92 patients or 40 per cent of those who received psychiatric service. Of the 92 patients followed up, 83 or 90 per cent are known to have shown marked improvement with reference to promiscuity. Forty six or 50 per cent ceased promiscuity. "Among those who continued sexual contacts, the change was sharply in the direction of fewer partners and more discrimination in the selection of partners".

In accordance with the figures of the third preceding paragraph, 78.6 per cent or 72 of the 92 girls were promiscuous and 20 were apt to become promiscuous. Presumably, 56 of the 72 promiscuous girls and 15 of the apt to become promiscuous girls had a venereal disease at the time of registration. It is known that these girls continued their treatments until no longer infectious, so they did not transmit infection to others during that time.

Promiscuity is roughly defined as having three or more sexual partners. Half of the 72 promiscuous girls, or 36, ceased promiscuity. If these 36 girls had continued their promiscuity at least half or 18 of them would have become infected and it is safe to say that each of the 18 would have infected at least 2 other persons. Thus, these 36 girls, if they had continued their promiscuity, would have resulted in 18 of them becoming infected

and in at least 36 other cases, or a total of 54 cases. This, then, was the minimum number of venereal disease cases which were prevented by the 36 girls ceasing their promiscuity. Twenty nine of the remaining 36 promiscuous girls showed marked improvement. Assuming that they were just half as successful as the girls who actually ceased promiscuity, their improvement resulted in the prevention of at least 7 cases among themselves and 14 cases among others, or a total of 21 cases. Thus the cessation of and improvement with respect to promiscuity among the 72 girls who had previously been promiscuous resulted in the prevention of at least 75 cases of venereal disease.

It is much more difficult to estimate the prevention of venereal disease which can be attributed to the 20 girls who were classified as apt to become promiscuous. Let us assume that 60 per cent of them, or 12, would have become promiscuous if they had not accepted psychiatric service. The result then would have been at least 6 cases among the girls themselves and at least 12 other persons infected by them, or a total of 18 cases. The saving, therefore, was 18 cases.

Thus it seems safe to say that the psychiatric service for the 92 girls whose present status is known resulted in the prevention of at least 93 cases of venereal disease.

Of the 365 girls who were interviewed by the psychiatric service, 63 per cent or 230 accepted and were given treatment. (Either Direct Service or Consultation Service.) We have already discussed 92 of these girls, which leaves 138 girls whose present status is unknown. Assuming that the service to this group was only half as successful as the service to the 92 girls whose present status is known (and there is actually no reason to believe that it wasn't just as good), there would have been a saving of at least 70 cases of venereal disease.

Thus, the total prevention resulting from the treatment of the 230 girls who received psychiatric service can be conservatively estimated at 163 cases.

Obviously, anyone can take issue with these figures, but it is very doubtful if anyone with a knowledge of the subject would consider them to be anything but under rather than overestimates. It should be noted that these figures have not considered the large number of cases which would result from the 163 cases. If each case transmitted his or her disease to but one other person, this would make an additional 163 cases, or 326 altogether. If it cost but \$60.00 to treat a case of venereal disease, this would represent a saving of \$19,560.00 in treatment alone.

It seems certain that the modest investment in the

psychiatric service has already proven a very profitable one from the point of view of venereal disease prevention alone. Actually, of course, the psychiatric service has even broader implications. If 150 or more girls a year can be rehabilitated to the point of becoming assets rather than liabilities to the community, the investment, or even a considerably larger one, would be, from a community viewpoint, an extremely profitable one. As time goes on, the service might well be offered to men as well as women.

If and when the Bureau of Mental Health is fully developed, it is quite probable that this service should be included in its program.

There are a number of other facts concerning the venereal disease service which are worth mentioning.

About 9 per cent of all the cases which came to the San Francisco clinic came as a result of having read the venereal disease signs in lavatories. More early cases come to attention through this simple means than by all other methods combined. This points clearly to the value of well prepared signs in lavatories; signs which advise the patient to see his physician or, if unable to do so, to come to the nearest public clinic, and giving the addresses and hours of such clinics. Signs which give only general information are unsuccessful; those which give specific locations and hours produce real results. The reason is obvious: the patient usually first becomes aware of his infection when using the lavatory.

During the Year 1944, the Health Department treated 1802 cases of syphilis. If these cases of syphilis had not been treated or were inadequately treated, experience has shown that about 20 per cent, or 360, would have developed neuro-syphilis (syphilis involving the central nervous system) and about one third of them, or 120, would have eventually become public charges in public institutions. If it costs approximately \$1,800.00 a year to care for a patient, this would mean an annual burden to the taxpayer of \$216,000.00. These figures take no account of the nearly 1200 gonorrhea patients treated. If untreated, an appreciable number of these would have developed gonorrheal arthritis and many would have become sterile. Investments in adequate treatment facilities pay big dividends in avoiding tax burdens in the future.

In discussing venereal disease control programs, past, present, and future, one fundamental point should be borne in mind. Venereal diseases constitute an important public health problem at all times, regardless of whether the period be one of war, post-war, or peace. A continuously well planned, aggressive program is essential if venereal disease is to be kept in check

and prevented from developing the tremendous personal and economic losses which would unquestionably result without such a program. It is greatly to be hoped that San Francisco will not make the fatal mistake, which was made by so many communities at the conclusion of the last world war, of abandoning or curtailing its venereal disease control services at the termination of the present war.

It is recommended:-

- (1) THAT THE PSYCHIATRIC SERVICE BE CONTINUED AS A VERY PROFITABLE INVESTMENT IN VENEREAL DISEASE PREVENTION.
- (2) THAT THE DIVISION OF VENEREAL DISEASE CONTROL MAKE A CAREFUL STUDY OF ITS INTERVIEWING METHODS IN AN EFFORT TO OBTAIN MORE COMPLETE INFORMATION ON SOURCE AND OTHER SEX CONTACTS.
- (3) THAT SERIOUS CONSIDERATION BE GIVEN TO THE POSSIBILITY OF ESTABLISHING A VENEREAL DISEASE TREATMENT CENTER IN THE MISSION AREA.
- (4) THAT RAPE OR SUSPECTED RAPE CASES BE EXAMINED BY THE PHYSICIAN ON DUTY IN THE CENTRAL EMERGENCY HOSPITAL.
- (5) THAT THE PRESENT PROGRAM OF VENEREAL DISEASE CONTROL BE CONTINUED IN THE POST-WAR AND PEACE PERIODS AS A NECESSARY MEANS OF PREVENTING THE TREMENDOUS PERSONAL AND ECONOMIC LOSSES WHICH WOULD OTHERWISE RESULT FROM THE VENEREAL DISEASES.

TUBERCULOSIS

The general responsibility for the control and supervision of tuberculosis rests with the Division of Tuberculosis Control which is a division of the Bureau of Communicable Diseases. The activities of the Division do not cover completely the public efforts to discover, treat and rehabilitate persons with tuberculosis. Its present program is confined largely to the conduct and administration of a large tuberculosis clinic at the San Francisco Hospital and to the public health nursing follow-up for this clinic and the chest clinics at Stanford and California. The Division has no direct responsibility for the admission, transfer or discharge of patients to or from the Tuberculosis Unit at the San Francisco Hospital or the Hassler Health Home. Neither does it have any direct relationship to the school case finding program carried on by the Bureau of Child Hygiene.

The present personnel of the Tuberculosis Control Division consists of the Chief, 3 part-time physicians, 1 head institutional nurse, 4 institutional nurses, 1 stenographer, and 1 part-time clerk, all working at the clinic. A public Health nurse is also assigned to the clinic from the Bureau of Public Health Nursing. In addition, there are a supervising nurse and 7 tuberculosis field nurses, responsible to the Bureau of Public Health Nursing, doing follow-up on all tuberculosis cases. This makes a total of 20 persons. The Chief of the Division is actually assigned temporarily as Superintendent of the Hassler Health Home so that the Director of the Bureau of Communicable Diseases is also acting as Chief of the Tuberculosis Control Division.

Appropriations for the Division of Tuberculosis Control, for the fiscal year 1944-1945, total \$54,541.00 or 7 cents per capita.

Private institutional facilities for the care of tuberculosis in this area consist of three small sanatoria. Public facilities for dealing with the tuberculosis problem in the county consist of:-

- (a) The Tuberculosis Clinic at the San Francisco Hospital (Open 6 mornings a week and one evening). Yearly attendance about 19,000 visits.
- (b) The Chest Clinic at the Stanford out-patient department. (Open 3 mornings a week). Yearly attendance about 1,250.

- (c) The Chest Clinic at the California out-patient department. (Open 3 mornings a week). Yearly attendance about 450.
- (d) The follow-up service by public health nurses of the Department of Public Health.
- (e) The tuberculin testing and X-Ray program carried on in the schools by the Bureau of Child Hygiene.
- (f) The Tuberculosis Unit of the San Francisco Hospital. (Originally about 500 beds by construction; by present usage about 300 beds by construction but about 375 by occupancy).
- (g) The Hassler Health Home with a capacity of about 268 beds.
- (h) The work of the California Tuberculosis Association.
- (i) The work of the San Francisco Tuberculosis Association.
- (j) The various County Tuberculosis Sanatoria for persons who are not residents of this county but may be eligible for state care.

The Tuberculosis Clinic at the San Francisco Hospital is open every morning except Sunday from 8:30 to 10:30 for admission of patients. Physicians work from 9:00 to noon or after. There is also a clinic on Wednesday evening. Pneumothorax re-fills are given Tuesdays and Fridays. Saturday mornings are devoted largely to children. The Wednesday morning clinic is essentially for Chinese and an interpreter is present.

The Clinic is under the general supervision of the Chief of the Division of Tuberculosis Control (at present the Director of the Bureau of Communicable Diseases), but is conducted by three part-time physicians who are well trained and experienced in tuberculosis. Also in attendance are a public health nurse, 1 head institutional nurse, 4 institutional nurses, a clerk-stenographer and a part-time file clerk.

Principal sources of referral to the Tuberculosis Clinic are from:-

- (a) Tuberculosis nurses of the Health Department.
- (b) Other nurses and personnel of the Health Department.

- (c) The San Francisco Hospital, particularly its follow-up clinic.
- (d) Private physicians.

All three clinic physicians are on duty at each morning clinic but only one is present at the Wednesday evening session.

Follow-up service for this and the other two tuberculosis clinics is provided by district public health nurses in areas where there is generalized nursing and by tuberculosis nurses in other areas. The follow-up work for the Stanford and California chest clinics takes about three fourths of the time of a public health nurse.

The tuberculosis control facilities of the area seem reasonably adequate and there are excellent individual efforts in tuberculosis control but the program, taken as a whole, lacks coordination and unification of planning.

To illustrate: The Tuberculosis Clinic at the San Francisco Hospital does an excellent job but its work is not as effectively coordinated with that of the Tuberculosis Unit of the San Francisco Hospital as it might be. The clinic makes its recommendations for hospitalization but the Social Service Department at the San Francisco Hospital makes the final decision as to admission, which we believe is not sound. The specialized tuberculosis public health nurses, under the guidance of a supervising nurse, constitute practically an independent entity. While these nurses are, as they should be, members of the Bureau of Public Health Nursing, they do not appear to be responsible to the Division of Tuberculosis Control in any way. For example, the Specialized Tuberculosis nursing group keep the record of tuberculosis cases but they are never reviewed by a medical man from the Tuberculosis Division. There is no modern tuberculosis register. The question of transfer from the Tuberculosis Unit of the San Francisco Hospital to the Hassler Health Home is a matter for discussion between the chiefs of the tuberculosis staffs and the Superintendent of Hassler, but no one person is actually responsible for making decisions. The tuberculin testing and X-Ray program in the schools (largely in junior high and high schools) is not coordinated through the Division of Tuberculosis Control. To be sure, referrals are made by this service to the Tuberculosis Clinic but there is no review and coordinate planning of the program.

Aside from this lack of coordination and unification of planning, the greatest weaknesses of the tuberculosis control

program lies in its complete failure to enforce quarantine for tuberculosis and in the unwarranted authority which is granted social service in making decisions concerning the hospitalization of tuberculosis cases. Decisions with respect to admission, transfer and discharge of tuberculosis cases should be the definite responsibility of the Chief of the Tuberculosis Control Division or Tuberculosis Controller (to be spoken of later). For example, if there are 10 cases of tuberculosis awaiting hospitalization and 5 available beds, the decision as to which 5 cases should be hospitalized is most certainly a responsibility of the medical person in charge of tuberculosis control and not that of social service.

No program of tuberculosis control can hope to be as effective as it should be unless tuberculosis quarantine is enforced. At the beginning of the Year 1944 there were 579 known active cases of tuberculosis at home. Of this number 239 had been in the hospital but left against advice - in short, "signed" themselves out. As long as this procedure goes on uninterrupted, tuberculosis will continue to spread. On the other hand, one can not expect to enforce quarantine with any degree of fairness until the hospital discontinues discharging tuberculosis patients for disciplinary reasons. The tuberculosis case who is discharged for disciplinary reasons may be just as dangerous to his family and the community as the case who goes home against advice. It would appear that a considerable number of those discharged for disciplinary reasons have wilfully created disciplinary reasons in order to obtain their discharge. If recalcitrant cases were sent either to the psychiatric ward or to the locked ward in isolation for a few days, disciplinary problems would very probably be greatly reduced. Since tuberculosis cases at the Tuberculosis Unit are supposed to be bed patients, there would seem to be no hardship or injustice in taking the patient's clothes away from him and locking them up until such time as he had a legitimate use for them. This procedure should tend to minimize the practice of signing out.

There seems to be a totally unwarranted apprehension here about insisting on hospitalization of a case of tuberculosis. Some people think that one has to have a legally water-tight case before any attempt can be made to insist on hospitalization. We do not for a moment believe that this is true, and this belief is borne out by the experience of Los Angeles and Sacramento where hospitalization is insisted upon and where no serious legal difficulties have been encountered. What is needed essentially is not so much a "legally water-tight case" as a different approach to the patient. The patient should not be given the impression that he has a choice of to be or not to be hospitalized. He should be made to understand that he is to be hospitalized, that the public health nurse will visit him and help him in making the necessary arrangements at home, and will notify

him as to what day he is to go into the hospital. The same philosophy of approach should be adopted in talking to patients about transferring from the Tuberculosis Unit to the Hassler Health Home. (It is rumored, but we have no substantiation for the rumor, that some members of social service have deliberately prejudiced patients against Hassler. If this be true, very serious damage is being done to the tuberculosis control program at great cost to the city). This method of approach - in which we assume that everyone knows that tuberculosis has to be hospitalized and that the case must be cared for in such manner and in such place as is best suited to his need - seems to be the only rational method of dealing with this all important problem. Having seen this method used, we are convinced that it will prove successful in the vast majority of cases. In the rare case in which the patient makes a big fuss, threatens to sue, etc., one can gracefully withdraw from the position of insistence if the case happens to be one in which the legality of quarantine might be questioned.

Tuberculosis is a very important problem in San Francisco. The death rate from it is higher than in many other cities and the 1944 rate is a good deal higher than the rate for 1943. Tuberculosis deaths (uncorrected for residence) totalled 363 in 1943 and 430 in 1944. The rates for the two years, per 100,000 population, were 46.8 in 1943 and 55.5 in 1944. This problem can not be dealt with satisfactorily until a more effective program of hospitalization and of keeping people in the hospital is established.

Services for children at the Tuberculosis Unit of the San Francisco Hospital as they affect the control of tuberculosis are seriously questioned. On February 23rd, 1945, there were 48 cases in the children's wards. Of this number 27 or 56.3 per cent are classified as childhood type, 11 or 22.9 per cent have adult type infection, 7 or 14.6 per cent have bone tuberculosis, 2 have pleural effusion, and one miliary tuberculosis. The child with miliary tuberculosis should, of course, remain at the San Francisco Hospital, probably also the two cases with pleural effusion. It would seem feasible and desirable to transfer the adult type and bone cases to the Hassler Health Home (not the children's building). The 27 children with childhood type or primary infection (except for the possible case or two with primary infection which seems destined to progress to the adult type infection and which should be transferred to Hassler) should be transferred to their homes or to some other institution or place, other than an institution for the care of adult type tuberculosis. There would seem to be no pressing need for the children's wards at the Tuberculosis Unit, particularly when there are so many adult type cases needing hospitalization.

Aside from enforced hospitalization and the discontinuance of the services of the social service division for tuberculosis (see section on the San Francisco Hospital) the greatest

need is for a well trained Tuberculosis Controller to plan and supervise the entire tuberculosis control program, including epidemiology, case finding, case holding, follow-up and rehabilitation. He should also be responsible for admissions, transfers, and discharges at the Tuberculosis Unit and the Hassler Health Home. He should be a physician with broad training and experience in tuberculosis, particularly in its public health aspects.

One of the very important benefits to be gained by the hospitalization of a tuberculosis patient lies in the educational program carried on for his benefit; a program designed to bring about a better understanding of his condition, what he has to do to get well and how to prevent the spread of infection to others. Such a program is being carried on at the Hassler Health Home. The physicians at the Tuberculosis Unit of the San Francisco Hospital carry on such an educational program within the limitations of the time they have to devote to it but comparatively little is being done by the nurses. The development of an in-service training program for nurses, designed to bring about a more effective educational approach to patients, would be highly desirable.

In order to insure necessary coordination and unification of planning, it is recommended:-

- (1) THAT A TUBERCULOSIS CONTROLLER BE APPOINTED TO HAVE GENERAL SUPERVISION OVER THE TUBERCULOSIS CONTROL DIVISION AND SUCH TUBERCULOSIS WORK AS IS CONDUCTED IN THE BUREAU OF CHILD HEALTH; TO BE RESPONSIBLE FOR ADMISSIONS, TRANSFERS AND DISCHARGES AT THE TUBERCULOSIS UNIT OF THE SAN FRANCISCO HOSPITAL AND AT THE HASSLER HEALTH HOME, AND TO CO-OPERATE WITH THE CALIFORNIA AND SAN FRANCISCO TUBERCULOSIS ASSOCIATIONS.
- (2) THAT THE HOSPITALIZATION OF ACTIVE CASES OF TUBERCULOSIS BE INSISTED UPON.

- (3) THAT ALL CASES OF TUBERCULOSIS ADMITTED TO THE TUBERCULOSIS UNIT OF THE SAN FRANCISCO HOSPITAL BE CONSIDERED AS ELIGIBLE FOR CARE AT THE HASSLER HEALTH HOME EXCEPT (a) MORIBUND CASES, (b) CASES NEEDING TUBERCULOSIS SURGERY WHICH CAN NOT BE PROVIDED AT THE HASSLER HEALTH HOME, (c) CASES NEEDING OTHER MEDICAL OR SURGICAL CARE NOT AVAILABLE AT HASSLER.
- (4) THAT TRANSFERS WHEN RECOMMENDED FROM ONE INSTITUTION TO ANOTHER BE INSISTED UPON.
- (5) THAT CHILDREN'S SERVICES AT THE TUBERCULOSIS UNIT OF THE SAN FRANCISCO HOSPITAL BE DISCONTINUED, EXCEPT FOR THE VERY OCCASIONAL CHILD WHOSE PROGNOSIS IS POOR, AND THAT ADULT TYPE CASES, THOSE WITH BONE AND JOINT INVOLVEMENTS, AND THOSE WITH PRIMARY INFECTIONS WHICH SEEM DESTINED TO PROGRESS TO THE ADULT TYPE BE TRANSFERRED TO THE HASSLER HEALTH HOME (NOT THE CHILDREN'S BUILDING).

Childhood type or primary infections, with the exception noted in the recommendation, should be transferred to their homes or to some other institution, other than an institution for the care of adult type tuberculosis.

- (6) THAT A CAREFUL REVIEW BE MADE OF ALL CASES NOW AT THE TUBERCULOSIS UNIT OF THE SAN FRANCISCO HOSPITAL TO DETERMINE WHICH CASES SHOULD BE TRANSFERRED TO THE HASSLER HEALTH HOME.

At present, the wards at the Tuberculosis Unit are crowded, while there are about 80 vacant beds at Hassler.

- (7) THAT A CAREFULLY PLANNED EDUCATIONAL PROGRAM BE DEVELOPED TO ACQUAINT PATIENTS AND POTENTIAL PATIENTS WITH THE FACILITIES AVAILABLE AT HASSLER AND WITH THE FACT THAT TRANSFER TO HASSLER MEANS GRADUATION; A PROGRESSIVE STEP IN THE REGIME OF TREATMENT.

Your surveyors can not understand why patients do not eagerly look forward to going to Hassler in preference to staying in the Tuberculosis Unit at the San Francisco Hospital.

- (8) THAT A MODERN TUBERCULOSIS REGISTER* BE ESTABLISHED AND BE REVIEWED PERIODICALLY BY THE TUBERCULOSIS CONTROLLER.
- (9) THAT THE SPECIALIZED TUBERCULOSIS NURSES, WHILE CONTINUING TO BE RESPONSIBLE TO THE BUREAU OF PUBLIC HEALTH NURSING FOR TECHNIQUES AND PROFESSIONAL GUIDANCE, BE MADE ADMINISTRATIVELY RESPONSIBLE TO THE TUBERCULOSIS CONTROLLER.
- (10) THAT ROUTINE TUBERCULIN TESTING PROGRAMS IN THE SCHOOLS BE DISCONTINUED IN FAVOR OF AN X-RAY PROGRAM OF SPECIAL GROUPS, INCLUDING HIGH SCHOOLS

* A splendid guide to the development of a modern tuberculosis register is the "Manual on Tuberculosis Registers", published by the National Tuberculosis Ass'n., 1790 Broadway, New York, 19, New York.

- (10) IN WHICH THE INCIDENCE OF TUBERCULOSIS IS
(Cont.) KNOWN TO BE HIGH.

In order to prevent the all too frequent practice of patients leaving the hospital against advice - in short, signing themselves out - it is recommended:-

- (11) THAT PATIENTS ADMITTED TO THE TUBERCULOSIS UNIT OF THE SAN FRANCISCO HOSPITAL HAVE THEIR CLOTHES LOCKED UP UNTIL THEY HAVE LEGITIMATE NEED FOR THEM.
- (12) THAT RECALCITRANT CASES, INSTEAD OF BEING DISCHARGED, (WHICH IS DANGEROUS AND UNSOUND) BE SENT TO THE PSYCHIATRIC WARD OR THE LOCKED WARD IN ISOLATION FOR A FEW DAYS.
- (13) THAT AN IN-SERVICE TRAINING PROGRAM FOR NURSES BE INSTITUTED TO IMPROVE THE TECHNIQUES AND EFFECTIVENESS OF THE EDUCATIONAL APPROACH TO TUBERCULOSIS PATIENTS UNDERGOING HOSPITAL TREATMENT.

MATERNAL AND CHILD HEALTH

Activities in the field of child health are the responsibility of the Bureau of Child Hygiene. Its work includes a medical guidance program for mothers and babies, medical examinations, and advisory service in the public and parochial schools, - elementary, junior high, senior high and junior college - medical supervision of special health classes in the schools, medical service for juvenile detention cases (males), diagnostic clinics for school children, dental and mental hygiene services.

Personnel.

The Bureau is in charge of a full-time Director. The staff numbers 41½, including 23 physicians (1 vacancy), (four of the physicians on a full-time basis, the balance part-time), 5 dentists - part time; 4 dental hygienists; 3 psychologists; 1 psychologist - part time; 1 optometrist - part time; 1 audiometer technician; and 1½ clerks.

The appropriations for 1944-1945 were as follows:- public health dentistry \$31,524.00; mental hygiene \$16,543.00; and the balance of child health services \$68,910.00. These total \$116,977.00. In addition, there is an appropriation for health centers of \$36,781.00, the major portion of which is for public health nursing but does include some medical work in the field of child hygiene.

Pre-natal Services.

Pre-natal work is not carried on under the Bureau of Child Hygiene. A clinic under the supervision of a well trained obstetrician on part time is conducted at the San Francisco Hospital, with sessions twice a week. Attendance is confined to those who are eligible for public care and are to be delivered at San Francisco Hospital. This service also includes post-natal examinations. The total admissions in 1944 was about 500.

The administration of the Federal Emergency Maternity and Infant Care Program comes under the Director of this Bureau. From October, 1943 to December 1, 1944, 2537 applications for care have been approved. In this period arrangements have been made for delivery service at 12 hospitals, including one Army hospital.

Well Baby Health Conference

Medical guidance is given to mothers with babies and young children, including examinations, individual advice on diet, habit training and care in general. Immunization is also provided against diphtheria, smallpox and whooping cough. Eight physicians are identified with this program.

The total registration in 1944 amounted to about 12,000.

Well-child conferences for mothers with babies and pre-school children are held at 15 different centers with a total of 29 sessions a week.

From the conferences observed a most favorable impression was gained. The professional people engaged possess an unusual background of training and experience.

The attention given patients is of a superior order. Records are orderly. This is a valuable service to the public and the contacts reach nearly a quarter of the children in the city under school age. This work unquestionably has a bearing on the city's very favorable infant mortality rate of 30 deaths under 1 year of age per 1000 live births.

School Health Service

Medical and nursing service is provided both public and parochial schools from the elementary through the high school and junior college. There are 15 physicians identified with this work, 4 on full time and the balance part time. This staff gives altogether 69 half days or sessions to this work weekly. On the basis of 5 sessions per physician, this is equivalent to 13.8 physicians if each worked 5 sessions weekly. Using 73,000 as the school population served, this provides a very fair ratio of 1 physician to 5300 children.

The school health service consists of examinations of (1) the kindergarten and first grade children who have not been examined by private physicians on entrance to school; (2) new entrants from other grades; (3) others who show no examination given previously; (4) transfers to secondary schools; (5) pupils in the 9th grade and those graduating from high school; (6) pupils on athletic teams and high school students whose physical condition is in question. In addition, diagnoses are made of suspicious communicable disease, and vaccination against smallpox and immunization against diphtheria are performed.

In the school year ending in June, 1944, some 15,000 medical examinations had been made as well as about 1,800 vaccinations and about 8,000 diphtheria immunizations.

In the elementary schools medical examinations were made with parents present in about 30 per cent of the cases.

Nurses in the schools made about 180,000 individual inspections of children and 24,000 classroom visits.

The school medical and nursing program is extensive. The service extends to high schools which are so frequently omitted in many communities. This is most commendatory. The capabilities of the medical staff are well above the average. The proportion of nurses to pupils is fair. There are many indications in the procedures and the forms used of a good type of service. San Francisco is fortunate in having adequate medical service for school children and a unified public health nursing service, nearly half of which is on a generalized basis.

In the over-all plan, however, there is opportunity for improvement with more effective use of the available services. What is needed is reallocation of responsibilities and a much greater participation of classroom teachers in the school health program.

As it is, too much time is devoted to routine examination of certain grades. Examinations might better be limited largely to children selected by teachers and nurses. A more thorough examination is possible when the physician has available the teacher's comments on the history of the child in the classroom. Because of her daily contacts with the child, no one but the teacher can supply this information. In the absence of this information, the physician is limited in his procedure. He can not see by looking at the child the repeated absences from various illnesses that occurred previously during the term. Nor can he take into account unusual behavioristic traits that have been occurring in the classroom.

This information, coupled with that from the parent on the home history of the child, gives a broader background against which to interpret the gross physical findings at the time of the examination.

The presence of the parent at the examination is conducive to follow-up attention by the parents. This saves home follow-up visits on the part of the nurses.

It is realized that during the war period, with so many mothers engaged outside the home, it is difficult to have parents

present at the examination. The proportion of 30 per cent of parents present is thus a fair record, under the circumstances. This proportion ought to be doubled, however, after the conclusion of the war.

To accomplish the goal of centering examinations on children referred by teachers and nurses for cause in place of the more rapid and limited routine examinations without a history, a much greater participation of classroom teachers in the health program is needed.

In addition to the medical record now kept by the physicians and nurses, there ought to be a pupil's health card kept by teachers. This card would carry a cumulative record of successive teachers' observations relating to the health of the child over the years and would be transferred with the child as he moves from room to room and school to school.

A closer collaboration between teachers, nurses and physicians and a ready means of exchange of information would improve the value of the examination to the advantage of the individual child.

With the teachers' health cards available, the nurse would find it desirable to meet with each teacher at least once a year to review each individual card and thus jointly select for examination the children whose record indicated the need and those who had not been referred previously.

The tabulation of individual physical defects found and corrections made as is now done is not particularly helpful. The last year's record shows 2,235 cases of defective vision found and 2,953 cases corrected. Obviously the corrections include many cases found in previous years. The recording of tonsils or enlarged cervical glands may be insignificant by themselves. They may be part of an important picture, such as rheumatic fever. From an administrative point of view, it would be much better to record items indicating progress made during the year in getting work done that needs to be done. Thus a nurse might be covering schools having 70 classrooms. With the program calling for a teacher-nurse conference at least once annually, the record would be made each month of the classroom conference held and those remaining to be done. If the same form of record was kept of other services - examinations of entering children, number of referred cases, examination of referred cases, those receiving medical attention and the like, the workings of the program are visible. The progress of work at any time in the light of the work to be done is a clear guide to the Supervisor, and shows where work is falling behind and where supplementary aid may be necessary.

Mass tabulations of physical defects do not show the work load in terms of children, as a child may have several apparent defects, some of significance, others not.

The main purpose of the school health program is to provide an educational medical experience that will aid children and parents. The aim is not just the labeling of an apparent defect (few of us are free from some defect), but medical guidance and corrective attention where necessary at the hands of a private physician or clinic.

With a cumulative record card, examinations of athletic participants do not need to be repeated. The examination could then be limited to those for whom no history was available, and directed specifically at those features which have a bearing on a pupil's ability to participate in strenuous activity.

Adjuncts to the medical service in the schools are the diagnostic clinics conducted by the Department of Health. A cardiac clinic is held, one session weekly; an eye clinic, one session weekly; an otological clinic for deafened children, two sessions weekly.

There are also dental clinics and child guidance and mental hygiene clinics. Tuberculin tests are performed at the main center on Grove Street, one session weekly, and chest X-Rays are available on 5 sessions a week.

SPECIAL TUBERCULOSIS CONTROL PROGRAM

Case finding and protection of children against tuberculosis is carried on by a full-time physician in the school service.

Tuberculin testing of junior and senior high school children is planned to reach all these children annually. In the elementary grades it is done only in special situations where tuberculosis is unusually prevalent or where a teacher is discovered with tuberculosis.

Chest X-rays are made of the positive reactors and when active lesions are revealed appropriate care is arranged.

Children with positive reactions and chest pathology are classified into several grades. Those without significant chest pathology or with calcified lesions are followed up with X-rays for several years to make certain that no reactivation of the lesion occurs.

When any unfavorable chest condition is discovered, the physician on this work takes particular pains to explain the situation fully to the parents.

The use of the special health classes for some of the elementary school children selected in the tuberculin testing program is discussed under Special Classes.

This specialized program on tuberculosis control in the school field is unusual and more extensive than in many communities.

Whether the results yielded from annual testing of senior and junior high school pupils repay the effort put into this work is seriously questioned.

Where X-ray facilities are limited it would seem much more effective to use them for age, occupational and racial groups where tuberculosis is known to be most prevalent. Certainly there are such groups with much greater tuberculosis incidence than occurs among junior and senior high school pupils generally. Mass X-ray surveys of special groups, including high school students in areas showing particularly high incidence of tuberculosis, seem destined to supplant tuberculin testing programs followed by X-ray of positive reactors.

If X-ray facilities are adequate, then more would be gained by substituting this examination in place of tuberculin testing. Incidentally, the mass X-ray service should be extended to include all employees in the Board of Education who are in close contact with children.

SPECIAL CLASSES

The Board of Education maintains certain special classes designed to aid the health and well-being of children. There are lip reading classes suitable for children with marked loss of hearing, sight saving classes for those with limited vision, orthopedic classes for the physically crippled, and health classes primarily for children exposed to tuberculosis in the home, for cardiac cases, for those convalescing from illness, and for special cases called in general terms the "below-par" child.

By arrangement with the Department of Health, the admission and discharge of pupils is determined by the physicians in the Bureau of Child Hygiene. It is a sound policy to provide a medical basis for segregating children in this manner.

From an educational standpoint, segregation of children is not looked upon with favor unless there are sound reasons sufficient to more than compensate for the disadvantage of being set apart from the general run of children.

The health classes have a special rest and dietary regime, with cots provided and prepared food sent in from the kitchens of San Francisco Hospital. In addition to the hot noon meal, extra milk lunches are served mid-morning and mid-afternoon. In some instances, facilities for showers and special health instruction are provided. The classes observed were in the hands of unusually capable principals and teachers, who, together with the associated public health nurses, evidenced the greatest interest and devotion to their charges.

With limited facilities (for about 700 pupils in these 4 types of classes) set up and maintained at extra expense over the usual classroom, discriminating care should be exercised in selecting those, among the 44,000 elementary children in public and parochial schools, who are in greatest need of this care.

In the functioning of this program, however, there is indication that some children are admitted for causes not anticipated in the original plan. In addition to some medical conditions which do not appear in accord with the program, mentally retarded children and disciplinary cases also find their way into these classes. Furthermore, the length of stay in the classes appears to be determined, in some instances at least, not on medical grounds, but because of the objection of parents to their removal.

Evidence on some of these points is illustrated from a tabulation of the causes for admission as shown on the records of 162 children registered in one of the special health schools. (See next page).

While in most instances, at least, there is no reason to believe that these children would not be benefited by the special class regime - from the rest and feeding alone - there is a grave question as to whether the selection of children is appropriate. The city expends \$30,000.00 annually for food for these classes. It does not appear necessary or wise to utilize such facilities for mentally retarded children or for behavior cases, - unless there are cardiac or other health deficiencies also associated with the child who is retarded or who is a behavior problem. Nor do these facilities seem necessary for some of the other causes shown in the table.

Some children have stayed in the classes for several years. Of the 162 children on the register, about 50 were in the class the previous year. Forty eight children were dropped prior to September and 106 new children were admitted. Certainly children should not be admitted on minor pretexts merely to keep the classes filled to capacity. These matters should be thoroughly reviewed by the two departments concerned and the purposes of

Basis for Admission	Number of Children
Malnutrition - alone or associated with such causes as underweight, asthma, and nervousness.	51
Cardiac conditions - alone or with such designations as malnutrition, asthma, congenital aortic stenosis, colitis.	24
Tuberculosis Contacts or Positive Tuberculin Reactions, Typical designations on individual cards were: 'T.B. contact and negative tuberculin, healed hilum T.B., healing hilum T.B., arrested T.B., T.B. cervical adenitis.	23
No Record available	15
Asthma	11
Miscellaneous- Chronic otitis media, nephritis, post scarlet fever, chorea, growth on head, dietary disorder (ungraded).	9
Rheumatic fever	8
Medical Observation	7
Nervousness	5
Anaemic - (2 with definite anemia)	4
" Weakness - overfatigue, run-down condition, frequent colds	3
Bronchitis	2

the classes and the methods of admission and discharge sharply redefined. These discussions are already under way, and a much more discriminating medical review of cases has already been instituted in the Sunshine School by the Bureau of Child Hygiene. The policy of admission and discharge on medical grounds is sound. It should be neither circumvented nor handled on any but a high professional level.

To recruit children in need of special lip reading instructions, extensive hearing surveys are made by a health department technician using a 4A audiometer. Prior to this last year, about 10,000 children were tested, which meant completing the rounds of all elementary schools in about 4 years. In this last school year about 6,200 children were tested. The reduction in program was necessitated by loss of clerical service and the resulting need for the presence of the audiometer technician at the sessions of the otological clinic in health department headquarters.

Those with indications of hearing loss are then to be tested with a 2A audiometer operated by a special teacher in the schools. Those failing in this test are referred to the otologist. If children are not tested with the 2A audiometer they may be referred to the otologist directly from the 4A test. Recommendation to the lip reading class is made by the otologist.

This program is well planned in that the important decision of transferring a child from a regular class to a special segregated lip-reading class with the potentialities of psychological trauma that this may entail, is made only on competent medical grounds.

However, in going over the records of children examined by the physician, it is disturbing to find that some children have been placed in lip reading classes contrary to the recommendations of the physician making the ear examinations.

In one case, a child with a mild hearing loss as determined with the 2A audiometer was found by the physician to have wax in both ears. This was removed and the child was recommended to continue in the regular class. On a subsequent examination some time later the physician again removed wax from the ears and again recommended continuation in a regular class. On this occasion it was learned that the child was already in the lip-reading class.

Furthermore, it is understood that children are placed in lip reading classes on the basis of the 2A test alone or on the basis of whispered voice tests performed by a special teacher in the classrooms, regardless of any recommendation of the physician.

There is an angle to this subject from the standpoint of the school teacher. Sometimes there are children whose medical examination does not result in a recommendation for assignment for lip reading instruction. On the other hand, the classroom teacher may know from her own daily experience that certain children are hard of hearing. Remarks addressed to such children always have to be repeated several times before they are heard or understood. In addition, some of these children have one or both parents who have marked hearing deficiencies. The parents themselves want their children to have lip reading instruction and report that the family situation is greatly aided when children have learned lip reading.

The objectionable feature is to have the medical people feel that the otological recommendation is being ignored, and to have the school teachers feel that their actual experience of hearing loss in the classroom is not supported by the medical recommendation. It goes without saying that the physician concerned must be a competent otologist.

The solution is conference between the two groups with frank discussion of the different aspects and agreement on the course of action. Once a procedure is agreed upon it should be faithfully observed.

The differences which have been encountered in the past have already been greatly improved but there is still room for a clearer understanding.

From the children tested for vision defect in the school examinations, children are selected for referral to the ophthalmologist in the diagnostic eye clinic of the Department of Health.

Orthopedic cases assigned to special classes are selected by private physicians and by hospital clinics.

In all of the above instances an endeavor is made to have families seek private medical guidance so far as possible.

It is recommended:-

- (1) THAT THE NAME OF THE BUREAU BE CHANGED TO
MATERNAL AND CHILD HEALTH AND THAT IT INCLUDE
PRE-NATAL AND POST-NATAL SERVICES IN ITS
GENERAL PLANNING.

It is not contemplated that this recommendation would change the personnel or conduct of the pre-natal or post-natal services but would, rather, insure unified planning for the whole field of maternal and child health.

- (2) THAT A FULL-TIME WELL TRAINED NUTRITIONIST
BE ADDED TO THE STAFF OF THE BUREAU OF
MATERNAL AND CHILD HEALTH AT A SALARY RANGE
FROM \$275. to \$325. A MONTH.

The functions of such a nutritionist would be essentially those of a health educator specializing in nutrition. This function is much broader than that of a dietician in that she will concern herself not merely with the planning of meals but with the promotion of better eating habits in relation to the whole regime of living, including rest, exercise, occupation, etc. Her job is that of a professional salesman aiming at the improvement of nutrition in its broad aspects in the population generally.

The principal duties of the nutritionist would be:
(a) to teach public health nurses and other professional and non-professional personnel the elements of good nutrition, (b) to stimulate and assist organized groups to develop their own nutritional programs, and (c) to do a limited amount of direct service with special cases referred by physicians of the health department.

- (3) THAT CLASS ROOM TEACHERS TAKE A FAR MORE
ACTIVE PART IN THE SCHOOL HEALTH PROGRAM.

This participation, in addition to classroom instruction in health practices and community health facilities, should include the preliminary selection of children for medical examination, active responsibility for the dental health educational program, with the guidance of dental hygienists, and the preliminary testing annually of the vision of school children.

No increase in medical or nursing service can make up for what the classroom teacher alone is in position to do by reason of her close daily contact with children.

- (4) THAT AN INDIVIDUAL PUPIL HEALTH CARD
FOR THE CUMULATIVE ENTRY OF TEACHERS'
OBSERVATIONS BE ADOPTED IN THE SCHOOLS.

This card, kept in the classroom, is needed in addition to the existing medical card now kept by the nurse and physician. There is no such teacher's card at present.

The school health team needs teacher, physician, and nurse. Close cooperation and mutual exchange of information are essential for the best interest of the child.

- (5) THAT ROUTINE MEDICAL EXAMINATION OF SPECIAL
GRADES OTHER THAN THE ENTERING CHILDREN BE
DISCONTINUED IN FAVOR OF THE EXAMINATION OF
SELECTED CHILDREN REFERRED FOR CAUSE BY THE
CLASSROOM TEACHER TO THE PHYSICIAN THROUGH
THE NURSE.

While the training and capabilities of the medical staff are well above the average, the annual examination of grades without contributing history from parent or teacher is apt to be ineffectual in effort, in professional time taken, and in end results. It is conducive of the superficial and perfunctory type of examination. It is expecting of the physician the mechanical functions of the "electric eye" which momentarily glimpses one person after another as the crowd passes through the gate.

The school examination is not for the purpose of selecting soldiers who must be above a minimum height and weight, who must have more than a minimum number of masticating teeth and the like.

The school examination should be an educational experience for the child and family in high quality of medical guidance.

- (6) THAT THE ROUTINE TUBERCULIN TESTING PROGRAM OF JUNIOR AND SENIOR HIGH SCHOOLS BE DISCONTINUED IN FAVOR OF X-RAY SURVEYS OF SPECIAL GROUPS, INCLUDING HIGH SCHOOL STUDENTS, IN AREAS SHOWING A PARTICULARLY HIGH TUBERCULOSIS INCIDENCE.
- (7) THAT THE FUNCTIONS OF THE 4 TYPES OF SPECIAL CLASSES BE SHARPLY REDEFINED THROUGH CONSULTATION OF THE TWO DEPARTMENTS CONCERNED - EDUCATION AND HEALTH - CLEAR OUT POLICIES ESTABLISHED AS TO THE TYPE OF CASES ELIGIBLE AND AS TO THE RESPONSIBILITY FOR ADMISSION AND DISCHARGE.

The medical basis for admission, and in most instances for discharge, should be followed. Medical selection of cases should be improved and the collective experience of physicians, nurses and teachers should be utilized in outlining the basis of selection and discharge. Unsuitable cases should not be admitted to the classes without medical approval or against medical advice.

It is not uncommon over the country to encounter the situation found in San Francisco, namely the adjustment of numbers of eligible children and the full utilization of available facilities. If the supply of eligible children from medical recommendations is not sufficient to fill the classes, the remedy is not to fill up the gaps with others whose need for special class care is not soundly established. If facilities are greater than the need, the city is entitled to a reduction in expenses in staff and maintenance. It is quite possible that funds thus saved are needed to support other meritorious school health services not now adequately financed.

On October 1, 1944, there were 29 special health classes with an enrollment of 470 children. This represents 68 per cent of the total children enrolled in these 4 types of special classes. While advantageous from the standpoint of management, it is not clear that the concentration of classes at one point, as at the Sunshine School, serves the convenience of children as well as would the dispersion of classes one or two to a school. This dispersion of classes would make care available particularly for convalescent children for shorter periods of time. This entire

matter of balancing need, facilities and results deserves detailed study by the two departments concerned.

- (8) THAT A STENOGRAPHER BE PROVIDED FOR THE DIRECTOR OF THE BUREAU AND TWO CLERKS BE ADDED FOR SERVICE IN THE DIAGNOSTIC CLINICS AND SPECIAL CLASSES AND ASSISTANCE IN THE FIELD AND IN THE CENTRAL OFFICE.

At present not a single clerk is carried in the budget for this large bureau. Such stenographic or clerical service as is provided is borrowed from the nursing bureau which is likewise short of clerical service.

PUBLIC HEALTH NURSING

All public health nurses in the Department are grouped in the Bureau of Public Health Nursing. This includes several nurses assigned here but paid other than by the city. There are also a number of registered nurses working in the Conservation Branch of the Department but not part of the Bureau.

Personnel.

As shown in table on the next page, the Bureau includes a director, an assistant director, 16 supervising nurses and 87 staff nurses. There are also 5 clerks and 4 porters in this Bureau, making a total of 114.

The number of nurses in the Bureau, plus the 8 assigned to other bureaus, makes 113 in all. This is the total in the Health Conservation Branch of the Department and does not include nurses in the Institutional Branch.

This number of 113 nurses in a Health Department of a City and County of 775,000 people is only a fair complement, considering that the work covers elementary and secondary schools, foster homes, and institutional inspections.

On the basis of a recommended minimum standard of 20 nurses per 100,000 population, the number of public health nurses in the Health Conservation Branch of the San Francisco Health Department would be 155.

The ratio of supervisors (15)* to staff nurses (95) is about 1 to 6, a very fair proportion.

During the war emergency it has been necessary to fill vacancies with nurses of limited public health training and to give them in-service public health training. Thus there are 11 public health nurses on limited tenure appointments (terminating 6 months after the war), 2 registered nurses also on limited tenure, and 10 registered nurses on a 90 day emergency appointment. No sooner do the nurses in the last named category begin to learn the work than their term is concluded. Arrangements have finally been completed with the Civil Service Commission to carry these nurses in the limited tenure group. As the pay is less in this group than in the 90 day group, this is a factor to be reckoned with in the transfer.

* Exclusive of the University of California Supervisor who deals primarily with nurses in training at the University.

WORKING ASSIGNMENTS
OF PUBLIC HEALTH NURSES.

BUREAU OF PUBLIC HEALTH NURSING					Other :
Director and : Super- : Staff : Bureaus :					
Asst. Director : visors : Nurses : Divisions :					TOTAL
Central Administration :	2	:	:	:	2
Field Instruction :		: 1 ^a	:	:	1
Communicable Disease :		: 1	:	:	1
Tuberculosis :		: 1	: 7 ^b	: 5	13
Venereal Disease :		: 2	: 7 ^c	: 3	12
<u>Child Hygiene</u> :		:	:	:	
Maternal and Child Welfare :		: 1	: 6	:	7
Schools :		: 2	: 28	:	30
Foster Homes :		: 1	: 4	:	5
Institutional Inspections :		: 1	: 2 ^d	:	3
<u>Generalized Districts</u>					
Alemany :		: 1	: 7	:	8
Mission :		: 1	: 7	:	8
Chinese :		: 1	: 3	:	4
Civic Center :		: 1	: 8	:	9
Hunter's Point :		: 1	: 5	:	6
South of Market :		: 1	: 3	:	4
TOTAL :	2	: 16	: 87	: 8	113

- a - Paid by University of California. Instructs University Students
b - One paid by local Tuberculosis Society
c - One paid by State Department of Health
d - One a nurse who is also a housing inspector

Expenditures.

The appropriation for public health nursing for the present fiscal year totals \$251,569.00 or 32.5 cents per capita.

Organization and Activities.

The scope of nursing activities is indicated by the working assignments shown in the table on Page 86. In general, this includes service in clinics and child welfare conferences, field visitations and inspections, and the associated supervisory and administrative duties.

The service is partly generalized and partly specialized.

The city has been divided into 10 districts, as follows:-

<u>District</u>	<u>Year</u> <u>Established</u>	<u>Population</u> <u>1940 Census</u>	<u>District</u> <u>Headquarters</u>
I. Mission	1925	63,000	San Francisco Hospital
II. Chinese	1926	18,000	Quarters rented by City
III. Alemany	1931	63,000	Owned by City
IV. Westside	1932	75,000	Dept. Headquarters ^a 101 Grove Street
V. Hunter's Point	1943	39,000 ^b	Health Center in Housing Project
VI. South of Market	1944	67,000	Dept. Headquarters
Total Population		325,000	

These are the six districts already established.

Four other districts have been outlined but have not yet been established due to lack of a headquarters in the heart of the district. These are:

VII.	Noe Valley	68,000
VIII.	North Beach and Marina	107,000 ^c
IX.	Richmond	88,000
X	Sunset	56,000
Total Population		319,000

a - Will probably occupy rented quarters at 2200 Sutter Street by March 1.

b - This number includes 18,000 people now living in the Hunter's Point Housing Project.

c - This is exclusive of the 18,000 Chinese in this area who are included by themselves in District II.

The principle of generalized nursing is sound. In so far as possible, it is far better and more economical of time to have nurses in a limited area doing all services in that area than to have nurses doing only one type of service, such as tuberculosis, school or child hygiene, and ranging all over the city for a single service, crossing each other's paths and, at times, even creating the situation of having two or three nurses visiting in the same family. It is better that the family be a unit and that all contacts with the family come from the nurse assigned to the area. In this way, also, nurses become better acquainted with the problems of an area and with the families in that area.

Thus, from the standpoint of population, about half the city is now represented in generalized districts.

The population of existing districts is somewhat small for a full fledged head center district with a district health officer and having separate clinic services for tuberculosis and venereal disease. The topography of the city is such that a much larger district is not conducive to easy travelling by the nurses or people coming to the center.

Furthermore, in a city of 775,000 people it does not appear necessary to set up fully equipped health centers with clinic services. For the number of cases involved it would be more efficient to handle tuberculosis and venereal disease medical services at one or two points as at present.

The districts had better remain as generalized nursing districts with the inclusion of child welfare conferences and possibly dental clinics, special diagnostic clinics and mental hygiene conferences in some instances.

As the new districts are established, it is anticipated that some changes in boundaries will also be effected.

Of the 87 staff nurses in the Bureau only 33 are now assigned to the 6 generalized districts. The remaining staff nurses work in specialized services in which the nurse devotes all her time to a specialty such as tuberculosis, and covers the entire area outside the generalized districts.

Perhaps the comments on the division of service into generalized and specialized needs some further clarification. While the statements made are true in broad outline, yet it is a fact that even the nurses in the specialized services do a varying number of other services as well. This is illustrated in the table on the following page which represents an analysis made by the Bureau for the month of May, 1941. So far as can be ascertained, this distribution would be generally applicable today, except for the addition of venereal disease

service in which the field nursing work was not established at that time.

Thus, all nurses engage in generalized service to some extent. Even the nurses assigned to tuberculosis do some other services as well.

Spread of Nursing Services in Various Fields of Work.

(Analysis made by Bureau of Public Health Nursing
for the Month of May, 1941).

Nursing Services Performed in Various Fields of Work									
Assignments	Maternity	Infant	Pre-School	School	Adult	T.B.	Total	No. of Nurses	
Administration:	:	:	:	:	2	:	2	:	2
Maternal and Child Health :	631	:	437	:	721	:	253	:	461
	:	:	1	:	2504	:	8		
Institutional Inspections :	:	9	:	46	:	40	:	4	:
	:	:	:	:	243	:	6		
Generalized Districts :	375	:	292	:	650	:	1538	:	687
	:	:	:	:	842	:	4384	:	26
Elementary & High School :	:	35	:	301	:	1897	:	346	:
	:	:	:	:	5	:	2584	:	32
Tuberculosis :	:	6	:	18	:	7	:	20	:
	:	:	:	:	1191	:	1242	:	7
Totals :	1006	:	779	:	1736	:	3735	:	1520
	:	:	:	:	2039	:	10959	:	81

In the case of school service, and particularly maternal and child health, there is a very substantial generalized service. This will be even clearer from the table on Page 90, in which the services of four groupings are distributed, each in terms of percentage of service in different fields.

Comparison of Generalized and Specialized
Nursing Service (May, 1941, data).

Nurse Assignment	Percentage Distribution									
	Maternity	Pre-Infant	Pre-School	School	Adult	T. B.	Inst.	Insp.	Total	
Maternal and Child Health	: 25.	: 17.	: 29.	: 10.	: 18.	: .04	: 0	: 100.		
Generalized Districts	: 8	: 7	: 15	: 35	: 16	: 19.	: 0	: 100.		
All Specialized Services (Exclu- sive of General- ized Districts)	: 10.	: 7.	: 17	: 33.	: 13.	: 18.	: 2.	: 100.		
All Services	: 9.	: 7.	: 16.	: 34.	: 14.	: 19.	: 1.	: 100.		

Most interesting is the similarity of the distribution in the Generalized Services and the grouping of all Specialized Service, exclusive of the Generalized Service. In other words, a marked degree of success has been achieved in apportioning the Generalized Services to agree with the total of all the Specialized Services.

In May, 1941, also, a special time study was made by the Bureau of the various nursing services. In general, this is pertinent to the situation today with these modifications: There has been a reduction in educational conferences; there is less maternity hygiene work; there is new and more work in the field of tuberculosis; venereal disease nursing work has been added.

During May, 1941, there were 13,171 hours of service by 81 nurses. Expressed in percentages of time given to fields of work, the distribution was as follows:- (See Page 91).

Distribution of Nursing Time
May, 1941

Percentage of time spent in different
locations for each main service group.

		S e r v i c e G r o u p											
Time Spent in —	:	All	:	Adminis-	:	General-	:	Mat.&	:	Elem.&	:	:	:
	:	Fields:	:	tration	:	ized	:	Child	:	Second-	:	T.B.:	Insp.
		:	:	:	:	:	:	:	:	:	:	:	:
Schools	:	33.	:	0	:	26.	:		:	62.	:		:
Office and Clerical Work	:	31.	:	97	:	35.	:	27	:	12.	:	49:	77.
Visits	:	13.	:	0.3	:	14.	:	28.	:	7.3	:	22:	13.
Travel	:	9.4	:	0.7	:	9.2	:	14.	:	7.9	:	16:	7.5
Child Welfare Centers	:	6.6	:		:	12.	:	26.	:		:		1.2
Business Conferences	:	2.3	:	1.2	:	1.3	:	0.3	:	4.5	:	0.2:	0.3
Diagnostic Centers	:	1.9	:		:	1.2	:		:	3.7	:		
Educational Conferences	:	1.7	:	0.3	:	1.4	:	2.8	:	1.8	:	1.5:	1.2
Chest Clinic	:	1.0	:		:	0.2	:		:		:	11:	
Pre-natal Clinics	:	0.2	:		:		:	2.1	:		:		
Hospitals	:	.03	:		:		:		:	.07	:	0.3:	
TOTAL		:	:	:	:	:	:	:	:	:	:	:	:

Most striking is the relatively large amount of time spent in office and clerical services. This figure seems high for the combination of all service groups. It is particularly so in Tuberculosis, Generalized Districts, and Maternal and Child Health. The high figure for Administration is not unexpected, although more of this time might well be spent in educational conferences. The high figure for Institutional Inspections is somewhat understandable because of the necessity of writing up reports of inspections.

However, these results definitely point to the need of additional clerical service in the Bureau of Public Health Nursing. This conclusion is in line with the observations of the surveyors at the present time. It is evident from visiting offices and centers that nurses are engaged in a great amount of clerical duties that should and can be carried by clerks. At present there are only 5 clerks in the entire Bureau. Even recognizing the clerical service provided in connection with the medical bureaus with which the nurses are associated, the training and professional experience of public health nurses are being used on tasks that clerks should be doing.

Record work is inevitable. It cannot be escaped. Nurses must have available the previous history of families they have visited. Physicians must have recorded the progress of clinic and conference patients and the advice previously given. They must also know the character of previous treatments. No one would expect a doctor to treat patients from memory, nor can one expect a nurse to carry on her multitudinous duties without some recorded statement of what went on before. Notices must be sent out. Daily reports of work must be kept. Otherwise the administrators of the service can not keep informed on what is taking place.

The increased use of clerks will save appreciable time for work which only nurses, by reason of their professional training and experience can do. With the present shortage of nurses, particularly, it is hardly excusable, to say the least, to load nurses with these many clerical duties.

In addition to the saving in professional talents, there would ordinarily also be a saving in cost. However, with the present similarity in salaries of nurses and clerks, this monetary saving would not be forthcoming.

Education and group conferences of the nurses have long been the custom, but the pressure of work has seriously disrupted this plan in the last two years. Formerly, assigned periods for staff education according to a schedule mapped out well in advance were held every two weeks. Supervisors met in general conference every 3 or 4 weeks. Once a week the generalized nursing supervisors met with the school nurses.

Institutional Inspections.

Should circumstances be such that you find it desirable to place your elderly mother in a private boarding home, you want to be sure that the place is suitable and that proper care will be given for her comfort and well-being.

To give this assurance, both the State and the City supervise such places. They require, first, that the place have a permit and this is issued only after an inspection has been made. To insure continued good operation, other inspections are made from time to time. Certain requirements are laid down to which these institutions must adhere. If complaints are made, anonymously or otherwise, an investigation is made.

A fee is charged for the permit. This is good for one year and then must be renewed. No fee is charged for renewal.

In addition to 86 boarding homes for the aged, each having usually not over four boarders, there are also other types of institutions under permit and inspection. These include 34 nursing homes (not over 8 people in each home) for adults over 16; 11 health institutions for life care of the aged (ranging from 15 to 240 occupants); 7 children's institutions (with from 15 to 250 occupants); and 20 nursery schools with around 30 children in each school.

The nursery schools must renew their permits every 6 months, the others annually.

Permits are issued by the local Department of Health which is also deputized by the State Department of Social Welfare to issue permits for the State. Local permits only are required for the nursing homes and nursery schools.

Recently, the Board of Education has requested the Department of Health to take over the inspectional supervision of 22 additional nursery schools.

This inspection program comes under the Bureau of Public Health Nursing and is handled by a supervising nurse in charge, two nurses, one of whom is also a housing inspector, and a clerk.

Foster Home Inspection.

In addition to the private institutional service for children, there are many children cared for in individual homes, or foster homes as they are called. It is of concern to all parents that the foster families are the type of people who will take good care of children and have the facilities for so doing. This is a real service to soldiers overseas whose wives are at work in war plants.

State and local regulations have been drawn up to govern these matters. Permits are required, and the homes are inspected. It is required, for instance, that every foster mother first have an X-ray of her chest to assure absence of tuberculosis. Every member of the family must be vaccinated against smallpox. All children in the family under 10 years of age must be immunized against diphtheria. Other requirements as to diet and care for the boarded children are specified. A special child welfare conference in the health department is held for the children of foster mothers.

The responsibility for this work is carried by a group in the Bureau consisting of a supervising nurse, 3 staff nurses, the full time of one clerk and the part time of another.

This is a busy office with telephone calls from and interviews with people who want to become foster mothers and from those who want to place children. In 1940-1941 there were 710 applications from people who wanted to place children. In 1943-1944 the number had grown to 2519. In 1940-1941, 339 children were placed and in 1943-1944 the number was 659. In 1943-1944, there were issued 343 permits for foster homes; 71 permits were denied; 3 were revoked; and 358 were renewed. In 1943-1944 also the nurses discovered 379 homes which were not under permit, the reason being usually that families were unaware of this requirement.

This type of supervision by the Department of Health was initiated in 1903 by a city ordinance.

The office for this work is crowded. There is inadequate clerical service. Nurses type their own reports. Dictaphones could well be used here.

Future Development.

The organization of nursing work on a generalized basis is entirely sound and sensible. At the earliest practicable opportunity the remaining four districts with a district center should be established. This will require office space, facilities for getting lunches, a waiting room and examining quarters for mothers and babies, and in some instances perhaps space for a dental clinic.

Specialized services should give way to generalized services. This is entirely feasible for tuberculosis, maternal and child welfare, and elementary schools. Later on it may be feasible for venereal disease.

The high school work, while it should be identified with the district, will probably require most of the nurse's time in the school

building. Visits to homes outside the district should be by the nurses of that district.

Institution and foster home service will undoubtedly have to remain as specialized services.

With 33 nurses now distributed over the 6 established districts, there remains a potential pool of 37 nurses now in Specialized Services for establishing the remaining districts. This includes 7 in tuberculosis, 7 now in venereal disease, 6 in maternal and child welfare, and 17 in elementary schools.

Compensation.

It is obvious that salary rates are higher in San Francisco than in certain other places. This is indicated by the range of salaries for general clerical service of \$160.-\$200. a month, and for senior clerical positions \$200.-\$250. The salaries of social workers run from \$175. to \$215. a month.

Against this background, we do not understand the justification for a salary range of \$175.-\$200. for public health nurses and \$200. to \$250. for supervising nurses. The time spent in professional education for the R. N., and the additional training requirements for public health are far more than is expected of clerical workers. The public health nurse is more than the handmaiden of the doctor. She is rendering a service in clinic, conference, home visitation and inspection that requires not only a professional background but the ability to teach and demonstrate before individuals and groups, to ferret out sources and contacts of communicable disease, to carry on social work, including the securing of case histories, and primarily to engage in a public relations task that requires the best in tact and diplomacy. While working under supervision, the staff in the field are on their own and called on to use independent and discriminating judgment.

So far as we know, there is no comparable training schedule, nor, for the most part, responsibilities, required of the clerical worker.

Major Strengths of the Public Health Nursing Bureau.

The Bureau is in capable administrative hands.

The ratio~~x~~ of supervisors to staff is favorable.

Good progress has been made in the transition from specialized to generalized service.

A commendable attitude has been displayed in studying the workings of the Bureau from an analysis of the records.

There has been an intelligent adaptation to the war emergency in keeping the ranks of the nurses filled.

Major Weaknesses.

Nurses are doing altogether too much office work that clerks should be doing.

Supervisors are used in a number of instances to direct the work of only a few nurses. There is room for working out this allotment in a somewhat better manner. Staff nurses might be assigned as the "Nurse in Charge", reserving the supervisors for wider supervisory responsibilities. Needed consultants in specialized services for the generalized districts may well be assigned from the ranks of supervisors.

It is recommended:--

- (1.) THAT THE ORGANIZATION OF THE FOUR REMAINING NURSING DISTRICTS WITH HEADQUARTERS IN THE DISTRICT BE EFFECTED AT THE EARLIEST PRACTICABLE OPPORTUNITY.
- (2.) THAT THE SEVERAL REGISTERED NURSES NOW ATTACHED TO THE VENEREAL DISEASE AND TUBERCULOSIS DIVISIONS, WHO ARE ENGAGED IN PUBLIC HEALTH WORK, BE RESPONSIBLE NOT ADMINISTRATIVELY BUT TECHNICALLY AND PROFESSIONALLY TO THE BUREAU OF PUBLIC HEALTH NURSING.

When there are separate nursing groups there is a tendency to develop different standards of work, different hours, etc., all of which invites personnel difficulties.

- (3.) THAT AT LEAST 5 ADDITIONAL CLERICAL POSITIONS BE PROVIDED IN THE BUREAU OF PUBLIC HEALTH NURSING TO RELIEVE STAFF NURSES FROM CLERICAL DUTIES AND, IN TURN, TO RELIEVE SUPERVISORS FROM STAFF NURSE DUTIES.

While additional nurses are needed at present, an attempt should first be made to make more time of existing nursing staff available for nursing work by the employment of clerks.

- (4.) THAT THE SALARY OF STAFF PUBLIC HEALTH NURSES BE RAISED TO A RANGE OF \$175. to \$225.
- (5.) THAT THE SALARY OF SUPERVISOR OF PUBLIC HEALTH NURSES BE RAISED TO A RANGE OF \$235. to \$275.
- (6.) THAT THE SALARY OF THE ASSISTANT DIRECTOR OF THE BUREAU BE RAISED TO A RANGE OF \$280. to \$350.
- (7.) THAT THE SALARY OF THE DIRECTOR OF THE BUREAU BE RAISED TO A RANGE OF \$400. to \$500.

A review of the salary ranges for other bureau directors and for people in other administrative positions in the Department will reveal that the director of a professional bureau with a staff of more than 100 people calls for remuneration much more in keeping with the responsibilities entailed.

- (8.) THAT A LIBERAL CIVIL SERVICE ATTITUDE BE SOUGHT IN DEALING WITH THE STATUS OF THOSE NURSES ENGAGED WITH INADEQUATE PRE-SERVICE PUBLIC HEALTH NURSING TRAINING, WHO HAVE GIVEN ACCEPTABLE SERVICE AND HAVE RECEIVED IN-SERVICE TRAINING DURING THE WAR EMERGENCY.
- (9.) THAT NURSING CONFERENCES FOR CONTINUING EDUCATION BE RESUMED AT THE EARLIEST PRACTICABLE OPPORTUNITY.

PUBLIC HEALTH DENTISTRY.

As a recommendation is being made that a new Bureau of Public Health Dentistry be created this subject is discussed by itself. At present the dental service is a function within the Bureau of Child Hygiene.

Personnel.

The budget provides for a chief dentist, 10 dentists and 5 dental hygienists. At the present time there are but 5 dentists, including the chief dentist, and 4 dental hygienists on the staff. The appropriation for 1944-1945 was \$31,524.00.

There are four dental clinics in health centers and four in schools. At present work is being carried on at only 4 locations, 3 of the school dental clinics and one at a health center, having been closed for lack of staff.

Most of the dental clinic work is limited to elementary school children. The dentists work six mornings a week.

The dental hygienists do prophylactic work in the centers in the afternoon. Their time in the morning is spent in schools, examining children's teeth and giving talks to classes. Their work is divided between the elementary and junior high schools.

The dental program has shrunk steadily in the last five years. The attendance at dental clinics (service of dentists only) was 13,000 for the school year ending in June, 1944. In 1939-1940 the figure had been 34,000.

The loss of dentists to the military services has undoubtedly accounted for the reduction in the dental program. In normal times this program ought to be resumed on an extensive basis.

" Dental care is one of the most difficult problems in the field of public health because of its magnitude. Private care for children's services is not plentiful even in normal times.

To preserve teeth at 18 years of age means continual dental care from the pre-school age period. Attention to small cavities at the beginning lessens the corrective work in the years ahead. It means less tooth destruction and the prevention of loss of permanent teeth during the school age.

Dental attention at least annually is the only solution for the preservation of children's teeth. As it is, over the country generally, the proportion of school children with carious teeth is probably well over 80

per cent. This fact provides the basis for a dental hygiene program.

Instead of giving talks before classes and examining mouths to find children who should go to the dentist, it is believed that the dental hygienist could devote her time more profitably by guiding teachers to assume the responsibilities of the dental care teaching program.

As all children - not just a small selected group - need to go to the dentist - private dentist or clinic - annually, a program urging dental attention upon children and parents should be in the hands of the classroom teacher directly. Demonstration materials and guidance can be helpfully provided by the dental hygienist.

Corrective work by dentists should be tied up with an educational program focusing on young children, pre-school and early grades. Until a corrective program centers on young children we are but continuing to toy with the whole dental problem. We shall never really prevent, in the future, the discouraging disclosures of teeth destruction in the recent selective service examinations until this is done.

The dental program should be greatly enlarged.

Record keeping could be considerably improved. The addition of such an item as number of individual children receiving care should be made.

Compensation.

A salary of \$135. a month for dentists, who serve 6 sessions a week, is altogether too low in comparison with other part-time professional positions in the Department.

It is recommended:-

- (1.) THAT A BUREAU OF PUBLIC HEALTH DENTISTRY BE ESTABLISHED
TO ABSORB AND BROADEN THE STAFF AND FUNCTIONS NOW CARRIED
ON WITHIN THE BUREAU OF CHILD HYGIENE.

This work is now limited largely to the school child. The problem of clinic service for those above school age is still unmet. Facilities of this kind ought to be available in the city. The logical place for

such clinic services is in the Department of Health.

At the present time, with only 4 dentists on the staff, a full-time director is unnecessary. In fact, even a part-time director is unnecessary unless the major portion of his time is spent at the chair. It would seem better to assign a dentist in charge, who, while giving the majority of time at the chair in a clinic, would be available on occasion to visit other clinics to insure that the policies and program are being carried out properly.

Later, as this program and staff enlarge, the need for a full-time director, giving at least some time at the chair, could be given consideration.

(2.) THAT THE SALARY OF THE PART-TIME DENTIST BE RAISED TO \$200. A MONTH.

(3.) THAT THE ACTIVITIES OF DENTAL HYGIENISTS BE ALTERED FROM THAT OF DIRECT TEACHING OF CLASSES AND THE INSPECTION OF TEETH IN THE CLASSROOM, TO THE AIDING OF CLASSROOM TEACHERS IN THE PROMOTION OF DENTAL CARE.

This will greatly extend the influence of dental care education. Hundreds of teachers can reach far more children and parents than 4 dental hygienists.

MENTAL HEALTH.

This field of public health, which is recommended to be transferred from the Bureau of Child Hygiene and set up as an independent bureau, is thus discussed separately.

Personnel.

The staff consists of a part-time psychiatrist in charge, a part-time psychiatrist, 3 full-time and 1 part-time psychologists and 1½ clerks.

The appropriation for the year 1944-45 amounted to \$16,543.00.

Service is conducted at the Department headquarters building, the Mission, Alemany, and Hunter's Point Health Centers.

Activities.

The purpose of the work is both diagnosis and treatment of a wide variety of mental and behavior problems in the endeavor to adjust difficulties, prevent the worsening of behavior trends, and direct to institutions those requiring such disposition. The problems encountered may be more specifically stated as retardation in school, behavior problems in school, for mental rating only, mental deficiency (for commitment to the State Home), problems based on physical condition, nervous manifestations, abnormal or peculiar mentality, personality difficulties, serious and minor behavior problems, and other reasons.

It should be emphasized that the clientele is by no means wholly in the mentally defective grouping. In fact, nearly half of the cases are possessed of normal or superior intelligence. The problems of the latter are ones of adjustment of themselves to normal community living.

The age of cases ranges from 3 years to middle aged adults, the majority being in the group from 6 to 18 years.

The referrals of cases to this service come principally from educational institutions, hospitals or other medical sources, charitable children's agencies and juvenile courts.

This is an extremely important field of work and should have whole-hearted support. The family disruptions caused by the war experience are increasing, and will continue to increase, the calls for this service.

The demands for assistance are much greater than the present staff can meet. Requests for additional service have had to be denied. The recent extension of service in Hunter's Point, while helpful, is insufficient to meet the problems there encountered. Group work with mothers has been discontinued.

We visualize the growth and stabilization of this service under full time psychiatric leadership. Eventually, the special mental health service now carried on in the Division of Venereal Disease Control should be a part of the new Bureau.

It is recommended:--

- (1.) THAT A BUREAU OF MENTAL HEALTH BE CREATED TO ABSORB AND BROADEN THE FUNCTIONS NOW CARRIED ON IN THIS FIELD UNDER THE BUREAU OF CHILD HYGIENE AND ALSO UNDER THE DIVISION OF VENEREAL DISEASE CONTROL.

The work now being done by the mental hygiene unit is largely limited to the child. The stresses and disruptions in family life created by the war are bound to enlarge the need and opportunity for this service in the days ahead. This is a vitally important public health problem and steps should be taken to meet it with some greater degree of adequacy.

At present the psychiatrist in charge is understood to give 3 half days and the other psychiatrist 6 half days weekly to this work.

As this bureau develops the work will undoubtedly need the full time of a well trained psychiatrist.

ADULT HEALTH INCLUDING INDUSTRIAL HYGIENE.

At present, the San Francisco Department of Public Health has no program of industrial hygiene or adult health in its broad aspects. The rapid growth of the city and the fact that San Francisco seems certain to continue as an important industrial center point definitely to the need for such services.

While it may be infeasible to provide this service immediately, because of man power shortages, the establishment of a real Bureau of Adult Health including Industrial Hygiene should be a major objective in the near future. The minimum necessary personnel would include a physician well trained and experienced in industrial hygiene and, if possible, a basic training in public health administration, a well trained industrial engineer, and a capable chemist with a well equipped industrial hygiene laboratory.

The words Adult Health and Industrial Hygiene are used to designate the desirable scope of interest of such a Bureau. Actually, the word "industrial" is too limited a term because such a Bureau should become interested in the health of all occupational workers or persons gainfully employed, and their families as well, which practically embraces the whole field of adult health. However, the word "industrial" is retained in the suggested title since the entire of the Bureau would usually be on the basis of studying and solving problems in industrial hygiene. Using the industrial hygiene approach, an interest in not only the health of the workers, but of their families as well, can be developed.

The aim of a Bureau of Adult Health and Industrial hygiene should be to develop this broader interest in the whole field of adult health. It is not suggested that the personnel of this Bureau actually undertake activities beyond the scope of industrial hygiene. It is contemplated that the Bureau should seek to develop an interest in the entire field of adult health. As an interest is developed, the industrial hygienist should call upon the various Bureaus of the Department, Tuberculosis, Venereal Disease, Maternal and Child Health, Public Health Dentistry, Nutrition, et cetera, to implement that phase of the program.

The work of the Bureau, in addition to meeting specific requests for service, should include:-

1. Conducting educational programs on industrial health for physicians and nurses.
2. The development of self-initiated programs where the need and opportunity seem greatest.
3. Developing the medical and nursing educational phases of the program.
4. Stimulating a broad interest in the entire field of adult health which would bring into the program the activities of other bureaus such as Tuberculosis, Venereal Disease, Maternal and Child Health, Public Health Dentistry and Nutrition.

It is therefore recommended:-

- (1.) THAT A BUREAU OF ADULT HEALTH INCLUDING INDUSTRIAL HYGIENE BE ESTABLISHED AS SOON AS PRACTICABLE.

ENVIRONMENTAL SANITATION.

The section on Environmental Sanitation would consist of the Bureaus of Food and Sanitation, Milk, Meat, and Plumbing. At present these four bureaus are responsible directly to the Director of Public Health. While the Department has, in the past, had the consultant services of a well qualified public health engineer, there is no full-time public health engineer in the Department. This is one of the most important personnel deficiencies in the Department. Each of the bureaus dealing with services in the field of environmental sanitation has problems which need, for their proper solution, the services of a well trained public health engineer.

As a means of coordinating the activities of the several bureaus in environmental sanitation and of providing public health engineering service for the department as a whole, it is recommended:-

- (1.) THAT A WELL TRAINED & EXPERIENCED PUBLIC HEALTH ENGINEER BE EMPLOYED AS DIRECTOR OF THE SECTION OF ENVIRONMENTAL SANITATION AND TO GIVE PUBLIC HEALTH ENGINEERING SERVICE TO THE ENTIRE DEPARTMENT OF PUBLIC HEALTH. HE SHOULD BE PAID A SALARY COMMENSURATE WITH THE TRAINING AND EXPERIENCE OF THE INDIVIDUAL SECURED AND THE RESPONSIBILITIES OF THE POSITION.

In considering this recommendation it should be clearly understood that an engineer without public health training and experience would not be able to provide the services needed.

FOOD AND SANITATION.

The Bureau of Food and Sanitation has a total personnel of 53, including the Director, 4 Supervising Inspectors, 31 Food and Market Inspectors, 13 Housing-Industrial Inspectors, and 4 Clerk-stenographers. This is the personnel provided for in the budget. Actually, at present,

there are 5 vacancies: 4 market-food inspectors and one housing-industrial inspector. Appropriations for 1944-1945 total \$190,790.00, or 24.6 cents per capita. Income from inspection and license fees, for the preceding fiscal year, totalled \$121,657.50 or 15.6 cents per capita. While this income goes back into the general funds of the City, this, nevertheless, means that food and sanitation services actually cost the City, in terms of tax funds, but \$69,132.50 or 9.0 cents per capita.

The Bureau is capably administered and its work has shown great improvement during the past few years. Up to two years ago the services of the bureau were carried on by specialized inspectors. In addition to housing and industrial inspectors, there were special inspectors for markets, meat, poultry, food, and restaurants. This totally unnecessary degree of specialization prevented the rendering of service on a district basis, was, because of its specialization, inflexible, and resulted in a great waste of time.

Somewhat less than two years ago the degree of specialization of inspectors was reduced greatly, so that today there are in the Bureau of Food and Sanitation but two classifications of inspectors, Market-Food inspectors and Housing-Industrial inspectors. That this more generalized program is proving of real benefit is attested to by three facts:-

1. This greater degree of generalization has made possible the rendering of services on a district basis (where one, but in this case two inspectors carry on all services in a given district) which has eliminated a very substantial amount of unnecessary travel time and the necessity of having several inspectors visiting the same establishment.

2. The number of inspections for the Year 1944, - in short, the amount of work performed - is much greater in 1944 than in 1943. Inspections in the field now covered by housing-industrial inspections increased from 12,741 in 1943 to 15,068 in 1944, or an increase of 18. per cent. Inspections in the field of market-food inspection increased from 39,404 in 1943 to 64,449 in 1944, or an increase of 64 per cent. Total inspections of the Bureau in 1943 were 52,145; in 1944 they were 79,517, or an increase of 53. per cent. (It is important to note that there were no appreciable increases in personnel in these two years).

3. The great majority of inspectors now enjoy their work far better than they did under the previous program of specialization. It is certain that a group of persons who find enjoyment and satisfaction in their work will produce better results than a group who find their work routine or boring.

That the change from a highly specialized to a far more generalized program has resulted in a very real improvement of service seems certain. That a further change from the present plan to a completely generalized program, on a district basis, would result in still further improvement seems certain. There is nothing in any way incompatible between the work now being carried on by the two groups of inspectors, market-food and housing-industrial. Any person with training and experience in either of these categories can easily be trained to carry on the services required of the other. This fact has actually been proven by experience. Because of man power shortages it has frequently been necessary to use, temporarily, housing-industrial inspectors for work in the field of market-food inspectors and vice versa, and the results have been uniformly successful.

The following tables, a, b, and c, present the inspectorial services of the Bureau for the calendar year 1944. These tables are taken from a study made by the Director of the Bureau of Food and Sanitation. They are presented, not primarily to analyze critically the work of the Bureau, but, rather, to illustrate the type of record keeping and analysis which can be helpful (when kept over a period of years) in measuring progress and in future program planning. It is this type of analysis which other bureaus and divisions might profitably emulate.

Without going into detail, these tables bring out two important points:

1. That a very considerable proportion of inspectorial service is rendered from which no income is derived (much of it just as important and sometimes more so than the services which are required legally for licenses, permits and inspections from which income is derived). This fact helps to explain why it is impossible to expect license, permit and inspection fees to cover completely the cost of health protection in the field of environmental sanitation.

2. While there seems no doubt but that services are more equitably distributed now than in previous years, there are still some discrepancies between the amount of service rendered and the public health importance of the type of business for which the service is rendered. For example, it seems probable that groceries - because their public health implications are less important than many other places - are receiving more than their proportionate share of inspectorial services. It is the type of analysis, as illustrated in Table c, that will make possible the discovery of and, therefore, the correction of such discrepancies.

TOTAL INSPECTIONS 1944 (Calendar Year)

HOUSING-INDUSTRIAL INSPECTORS.

	Inspections	Per Cent.
Apts., old and new	3815	25.6
Hotels, old and new	1046)	27.7
Dwellings & Misc.	<u>3231)</u>	
Sub-total	8092	53.3
Dry Goods and Cleaners	111	.7
Factories (not food)	783	5.2
Garbage and Swill Trucks	1502	10.0
Dumps	580	3.9
Laundries	377	2.5
Reservoirs	862	5.8
Wells	98	.7
Swimming Pools	326	2.2
Theatres	248	1.7
Schools	85	.6
Miscellaneous	1588	10.6
Others*	<u>416</u>	<u>2.8</u>
Sub-total	6976	46.7
TOTAL	15068	100.0
Total Inspections in 1943	12741	Per cent increase from 1943 to 1944 - 18.3

*Others includes gas poisoning, garages, junk stores, office buildings, printers and binders, stables and kennels and misc.

TOTAL INSPECTIONS 1944 (Calendar Year)

MARKET - FOOD INSPECTORS.

	Inspections	Per Cent.
Bakeries	2443	3.8
Butchers	4620	7.1
Fish-Shellfish	1103	1.8
Fruits-vegetables	2960	4.5
Groceries	7314	11.4
Markets-Delicatessens	4589	7.2
Sausage and other food factories	5088	7.8
Restaurants	22078	34.3
Soft drinks	3118	4.9
Salvage dealers	1977	3.1
Poultry	1751	2.7
Schools	126	0.2
Others*	<u>7282</u>	<u>11.2</u>
Total	64449	100.
"		
Total Inspections in 1943	39404	Per cent increase from 1943 to 1944 - 63.6

* Includes candy factories and candy stores (1.6), coffee roasters (0.1), egg candling and eggs (0.2), liquor concerns (2.4), Misc. (5.7), warehouses (0.6), wineries (0.2), others (0.3), spice grinding (0.1).

INSPECTION SERVICE OF THE BUREAU
OF FOOD AND SANITATION, IN THE YEAR 1944.

Showing the relationship of case load to inspections,
and inspections per unit or place.

(1)								
	: Per cent of		:	Per cent of:		No. of	:	No. of: In-
	:Case	: Inspec-	:	:Case	: Inspec-	:Units or:	:	Inspec+ spec-
	:Load	: tions	:	:Load	: tions	:Places	:	: tions : tions
	:	:	:	:	:	:	:	per
								unit
								or place
HOUSING-INDUSTRIAL								
Apartments	:75.6	: 25.6	:	36.6	: 4.8	: 5,439:	3,815:	0.7
Hotels	:11.8	: 6.9	:	5.8	: 1.3	: 854:	1,046:	1.2
Factories (not food)	: .6	: 5.1	:	0.2	: 1.0	: 34:	783:	23.0
Laundries	: 4.0	: 2.5	:	2.0	: 0.4	: 299:	377:	1.26
Miscellaneous	: 8.0	: 10.6	:	3.9	: 2.0	: 579:	1,588:	2.7
Others (3)	: -	: 49.3	:	-	: 9.4	: -	:7,459	-
Sub-total	: 100.	100.	:	48.5	: 18.9	: 7,205:	15,068	-
MARKET-FOOD								
Breweries	: .2	: -	:	0.1	: 0.03	: 15	: 22	: 1.5
Bakeries	: 3.2	: 3.8	:	1.6	: 3.1	: 245	:2,443	: 9.97
Butchers	: 3.7	: 7.1	:	1.9	: 5.8	: 285	:4,620	: 16.2
Liquor Concerns	: 2.0	: 2.2	:	1.1	: 1.9	: 158	: 1,542:	9.8
Groceries	: 13.3	: 11.4	:	6.9:	9.2	: 1028	: 7,314:	7.1
Markets and Delicatessens	: 4.5	: 7.2	:	2.4	: 5.8	: 351	: 4,589:	13.1
Sausage								
Factories	: .6	: 3.7	:	0.3	: 3.0	: 48	: 2,414:	50.3
Other Food								
Factories	: 13.4	: 4.1	:	7.0	: 3.4	: 1,036	: 2,674:	2.6
Restaurants	: 35.7	: 34.3	:	18.6	: 27.7	: 2,765	:22,078:	8.0
Candies and								
Soft Drinks	: 3.9	: 6.5	:	2.1	: 5.3	: 311	: 4,188:	13.5
Salvage Dealers	: -	: 3.1	:	0.04:	2.5	: 6	: 1,977:	329.5
Poultry	: 6.6	: 2.7	:	3.5	: 2.2	: 512	: 1,751:	3.4
Schools	: .6	: 0.2	:	0.3	: 0.2	: 45	: 126:	2.8
Peddler Wagons	: 2.9	: -	:	1.5	: 0.01	: 226	: 11:	0.04
Miscellaneous	: 8.1	: 5.7	:	4.2	: 4.6	: 624	: 3,655:	5.9

	1.		2.		No. of	No. of	Inspec-
	Per cent of	Case :	Per cent of	Case :	Units	Inspection	tions per
	Load :	tions	Load :	tions	or	tions	Unit or
						Places :	Place
Others (4)	: 1.3	: 8.0	: -	: 6.4	: -	: 5,045	: -
Sub-total	: 100.0	: 100.0	: 51.5	: 81.1	: 7,655	: 64,449	: -
Grand Total							
Food and							
Sanitation	:	:	: 100.0	: 100.0	: 14,860	: 79,517	:

(1) The case load and inspections here are based on the work of the Housing-Industrial inspectors as 100 per cent and of the Market-Food inspectors as 100 per cent.

(2) The case load and inspections here are based on the work of the entire bureau.

Case load in both columns (1) and (2) is based on the total number of units or places for which the number is known.

(3) Includes the following inspections where the number of units or places is not known:- Dwellings and Miscellaneous (3231), Dry goods and Cleaners (111), Garbage and swill trucks (1502), Dumps (580), Reservoirs (862), Wells (98), Swimming pools (326), Theatres (248), Schools (85), and Others (416), making a total of 7459 or approximately 49.3 per cent of total inspections made by the Housing-Industrial inspectors.

(4) Includes the following inspections where the number of units or places is not known:- canneries (19), coffee roasters (55), eggs and egg candling (136), fish and shellfish (1103), fruits and vegetables (2960), spicegrinding (46), warehouses (395), waters (bottled) (16), Wineries (120), Wharves (3), Ships and Ferry boats (2), and others (190), making a total of 5045 inspections.

For each of the four years of 1937, 1938, 1939, and 1940, the following table shows the number of cases of the following diseases: Tuberculosis, Syphilis, Gonorrhea, and Venereal Diseases.

Year	Tuberculosis	Syphilis	Gonorrhea	Venereal Diseases
1937	1,000	1,000	1,000	1,000
1938	1,000	1,000	1,000	1,000
1939	1,000	1,000	1,000	1,000
1940	1,000	1,000	1,000	1,000

Total

(1) The cases of the following diseases are based on the number of cases reported to the health department.

(2) The cases of the following diseases are based on the number of cases reported to the health department.

Each case is based on the number of cases reported to the health department.

(3) Includes the following diseases: Tuberculosis, Syphilis, Gonorrhea, and Venereal Diseases. The number of cases is based on the number of cases reported to the health department.

(4) Includes the following diseases: Tuberculosis, Syphilis, Gonorrhea, and Venereal Diseases. The number of cases is based on the number of cases reported to the health department.

Although not brought out in the tables, there are a great many inspections made as the result of complaints - most of them telephoned but some written - made to the Department. Written complaints are handled by the Director or some other person qualified to make decisions as to what action is indicated. Telephone calls are accepted by whoever answers the telephone and in most instances result in an inspector being sent out to investigate. Many of these calls turn out to have no public health significance and many of them could have been taken care of satisfactorily over the telephone if the person answering had been well trained in the work of the Bureau. A complaint office, manned by at least two well trained generalized inspectors, to which all complaints - both telephone and written - are referred, would more than pay for itself in terms of field inspection time saved, to say nothing of the satisfaction which it would give to the public.

There is no one in this Bureau or in the Department (except the Director) with any special training or experience in entomology. Insect and helminth (worm) vectors of disease, already a problem of some importance, may become aggravated and a menace of even greater importance as a result of the war. Either an entomologist should be employed or a well qualified inspector should be given special training in entomology.

In reviewing the Budget for 1944-1945 of the Department of Health, one will find under Communicable Diseases an item of 8 "rodent control" men. (At present - Jan. 1945 - only 5 are actually employed). There seems to be a very prevalent misunderstanding as to who these men are and what they do. Although paid for by the City, they do not work for the San Francisco Department of Public Health; they are assigned to and work for the U. S. P. H. S. Plague Control Laboratory. While performing a useful function, they are not engaged essentially in rodent control. They are not employed primarily to get rid of rats. They do catch rats, not to help people get rid of rats, but to sample the rat and flea population to determine the extent of plague infection. It seems necessary to call attention to these facts because so many people have the impression that the Department of Health has a corps of rat catchers upon whom they may call to get rid of rats. The Department of Health has no such personnel.

In San Francisco, as in most other communities, the responsibility of ridding a premise of rats and rat harborage rests with the property owner or the lessee. All inspectors of the Department of Health, whether they be in the Bureau of Food and Sanitation, Milk, Meat, or Plumbing, have rodent control as one of their functions. It is not their function to catch rats but, rather, to advise property owners, lessees and managers, of how to get rid of rats, rat harborages, and to effectively rat-proof their buildings. If only property owners, particularly owners, lessees or proprietors of food and food handling establishments fully realized the tremendous economic losses they suffer through rats, quite apart from the public health danger, they would exert their efforts toward not only ridding their premises of rats and rat harborages but toward effectively rat-proofing their buildings.

In order to place more emphasis on rodent control, it would seem wise to add at least 3 well qualified generalized inspectors to the staff of the Bureau of Food and Sanitation. The Bureau of Health Education (recommended in a preceding section) should prove very helpful in bringing about more effective rodent control. A well planned program of health education must form the basis for effective rodent control.

Persons or firms engaging in rodent control work for fees are licensed by the California Structural Pest Control Board, which is in the State Department of Professional and Vocational Standards. There are two unfortunate weaknesses of the Structural Pest Control Act of California. First it blanket-ed in all firms who were engaged in business prior to October 1, 1935, without any examination as to competency. Second, the staff of the Structural Pest Control Board is insufficient in number to check up on the competency of licensees. For these reasons, it would seem wise for the California Structural Pest Control Board to deputize the San Francisco Director of Public Health to enforce its ruled and regulations in San Francisco.

The present method of garbage collection probably does not of itself materially affect the rat population of the area. The fact that householders are not legally required to contract for garbage removal - and a very considerable number do not - does result in the creation and maintenance of unnecessary rat harborages. Garbage collection in San Francisco is "sloppy" and disagreeable from an aesthetic point of view, but the facts that collection vehicles pass through the streets, at times uncovered, and that there is a small amount of spillage, probably have very little to do with the rat problem. The aesthetically disagreeable features of the present system can only be avoided by: (1) passing an ordinance requiring householders to separate garbage from other refuse and (2) the purchase of modern equipment which will grind up the garbage while en route in an entirely covered vehicle. The plan will still not be completely effective unless, either the City provides universal garbage collection, or all householders (unless they have approved incineration equipment) are required to contract for garbage collection.

The transfer of garbage from collection vehicles to gondola cars at 6th and 16th Street does present a problem which may have a real effect on the rat population. While under constant supervision, this process of unloading and loading, nevertheless, does result in some accumulation of garbage. Scavenger companies should be required to do a better job of cleaning up at this point of transfer.

One fully realizes the great difficulty in maintaining high standards of sanitation in the preparation, handling and serving of food in war times because of the shortage of capable help and the unusually rapid turnover of personnel. Nevertheless, San Francisco, in common with many other cities, is to be criticized for not having pursued a more aggressive program, in terms of food handler instruction, to meet this difficult problem.

It is generally agreed that physical examinations of food handlers do not afford any real protection to the consumer of foods. Well planned, simple talks and demonstrations on personal hygiene and the hygiene of food handling seem likely to produce the most effective results as far as the protection of the consumer of food is concerned. No matter what disease the food handler might have, if he or she observed scrupulously all the rules of personal hygiene and the hygiene of food handling there would be little likelihood of transferring infection to the food consumer. Food handler cards might be issued to employees on the basis of their having complied with the rules and regulations of the Department of Health pertaining to instruction in personal hygiene and the hygiene of food handling. The card might read: "This is to certify that _____ has attended the course of instruction in personal hygiene and the hygiene of food handling required by the Department of Public Health".

In its initial stages the program should probably require attendance at a single session. Later on it may be found feasible and desirable to require attendance at two or more lectures and demonstrations.

In the formulation of such a program a few guiding principles should be borne in mind:—*

1. The program should include both employees and employers or managers.
2. The talks should be carefully planned, but short, and should include demonstration. The talk and demonstration should probably not be over 15 or 20 minutes. If movies are included, the period of attendance may be longer.

*Outlines of excellent programs of food handler instruction can be obtained by writing the Flint Department of Health, Flint, Michigan, and the Detroit Department of Health, Detroit, Michigan.

3. Talks and demonstrations should be planned for the intelligence age level of the employees - usually about 8 years.
4. Instruction should be informal and given to employees on a prearranged appointment basis. Best results can usually be obtained with small groups of from 8 to 15 persons. Questions and discussions by employees should be encouraged. Quiet and reasonably comfortable quarters, conducive to questions and discussion, are highly desirable.
5. Instruction should emphasize the need for and value of periodic complete physical examinations for the employee's own personal protection.

In order to implement the program in the field of food and sanitation, in the manner described in preceding paragraphs, it is recommended:-

- (1.) THAT THE PRESENT CLASSIFICATIONS OF MARKET-FOOD AND HOUSING-INDUSTRIAL INSPECTORS BE MERGED INTO A SINGLE CLASSIFICATION OF PUBLIC HEALTH INSPECTOR (SANITARIAN) AND THAT THE ENTIRE SERVICE OF THE BUREAU OF FOOD AND SANITATION (EXCEPT FOR SPECIAL INVESTIGATIONS AND STUDIES) BE RENDERED ON A GENERALIZED DISTRICT BASIS.
- (2) THAT THE TYPE OF ANALYSES NOW BEING CARRIED ON BY THE BUREAU OF FOOD AND SANITATION BE CONTINUED AS AN IMPORTANT MEANS OF BRINGING ABOUT A MORE EQUITABLE BALANCE BETWEEN SERVICE RENDERED AND THE IMPORTANCE OF THE HEALTH PROBLEM TO WHICH THE SERVICE APPLIES.

- (3.) THAT THE CITY RECOGNIZE THE FALLACY OF EXPECTING THE SERVICE OF THE BUREAU OF FOOD AND SANITATION TO BE ENTIRELY SELF-SUPPORTING SINCE A CONSIDERABLE AMOUNT OF SERVICE OF REAL HEALTH SIGNIFICANCE IS RENDERED FROM WHICH NO REVENUE IS DERIVED.
- (4.) THAT THE BUREAU OF FOOD AND SANITATION ESTABLISH A COMPLAINT OFFICE, STAFFED WITH WELL TRAINED PUBLIC HEALTH INSPECTORS, AS A MORE ECONOMIC AND EFFECTIVE MEANS OF DEALING WITH THIS ASPECT OF ITS WORK.
- (5.) THAT AT LEAST 3 GENERALIZED PUBLIC HEALTH INSPECTORS BE ADDED TO THE STAFF IN ORDER THAT MORE EMPHASIS MAY BE PLACED ON RODENT CONTROL.
- (6.) THAT HOUSEHOLDERS BE MADE AWARE OF THE FACT THAT "RODENT CONTROL" MEN ARE NOT MEN EMPLOYED BY THE DEPARTMENT OF HEALTH TO KILL RATS FOR THEM BUT ARE (WHILE PAID BY THE CITY) EMPLOYEES OF THE UNITED STATES PUBLIC HEALTH SERVICE PLAGUE CONTROL LABORATORY WHOSE FUNCTION IS TO ASSIST IN DETERMINING THE DEGREE OF PLAGUE INFECTION IN RATS AND FLEAS.
- (7.) THAT A COMPREHENSIVE HEALTH EDUCATION PROGRAM BE CARRIED ON TO ACQUAINT PEOPLE WITH THE NEED FOR AND VALUE OF GETTING RID OF RATS BY ELIMINATING RAT HARBORAGES AND BY EFFECTIVELY RAT-PROOFING BUILDINGS.

- (8.) THAT THE CALIFORNIA STRUCTURAL PEST CONTROL BOARD BE REQUESTED TO DEPUTIZE THE SAN FRANCISCO DIRECTOR OF PUBLIC HEALTH TO CARRY OUT ITS FUNCTIONS IN THIS COUNTY.
- (9) THAT THE CITY OF SAN FRANCISCO INSIST ON A MORE EFFECTIVE CLEANING UP OF THE PREMISES AT AND ADJACENT TO THE FOOT OF 16th STREET AND 6th STREET, WHERE GARBAGE IS TRANSFERRED FROM COLLECTION VEHICLES TO GONDOLA CARS.
- (10.) THAT THE CITY OF SAN FRANCISCO PASS AN ORDINANCE REQUIRING THE HOUSEHOLDER TO SEPARATE GARBAGE FROM OTHER REFUSE AND THAT AT THE EARLIEST OPPORTUNITY THE CITY PURCHASE OR ARRANGE FOR THE PURCHASE OF MODERN GARBAGE COLLECTION EQUIPMENT.
- (11.) THAT THE BUREAU OF FOOD AND SANITATION INSTITUTE A PROGRAM OF HEALTH EDUCATION FOR FOOD HANDLERS DESIGNED TO BRING ABOUT A BETTER UNDERSTANDING OF THE FUNDAMENTALS OF PERSONAL HYGIENE AND THE HYGIENE OF FOOD HANDLING AS THE ONLY FRUITFUL MEANS OF AFFORDING ANY REAL PROTECTION TO THE CONSUMER OF FOODS.
- (12.) THAT EITHER AN ENTOMOLOGIST BE EMPLOYED OR A WELL QUALIFIED INSPECTOR BE GIVEN SPECIAL TRAINING IN ENTOMOLOGY.

(13.) THAT ALL HOUSEHOLDERS, UNLESS THEY HAVE APPROVED INCINERATION EQUIPMENT, BE REQUIRED TO CONTRACT FOR GARBAGE COLLECTION.

(14.) THAT CONSIDERATION BE GIVEN TO THE NEED FOR EMPLOYING A MAMMALOGIST OR RODENT CONTROL EXPERT.

MILK.

Services in the fields of dairy and milk supervision and control are carried on by the Division of Dairy and Milk Inspection (recommended to be the Bureau of Dairy and Milk Control). Civil Service has said that there should be a Bureau of Dairy and Abattoir Inspection and that it should be directed by a veterinarian. This is not a logical combination. The two services of milk control and supervision and meat inspection are totally different and involve the use of personnel of different training. There should be two separate bureaus. The meat inspection service, since it consists essentially of ante-mortem and post-mortem examinations of animals, should be directed by a veterinarian. The control and supervision of milk and dairy products need not be directed by a veterinarian. Most of our effective milk control officers in the United States are not veterinarians but have had special training in this highly specialized field.

The Bureau of Milk and Dairy Supervision (at present designated as the Division of Dairy and Milk Inspection) has a personnel of 15½, including the Chief, 7 dairy inspectors, 2 veterinarians (classified as dairy inspectors), 4 food inspectors, 1 clerk-stenographer, and 1 part-time clerk. At present there is one vacancy in dairy inspection.

Appropriations for milk and dairy inspection, for 1944-1945, total \$61,639.00. (This is estimated as there is a single appropriation for Dairy and Abattoir Inspection of \$86,999.00). This amounts to approximately 8 cents per capita. Income from dairy and milk inspection totalled, in the past fiscal year, \$55,055.25, or 7.2 cents per capita, which means that milk control actually cost the city, in terms of tax funds, but \$6,583.75, or 0.8 cent per capita.

The milk control program is capably administered and is one of the most highly developed and effective programs in the Department. In 1933 San Francisco passed an ordinance requiring universal tuberculin testing of cows and universal pasteurization except for certified milk. Today the city has no raw milk. This comparatively early action on the part of the city of course has much to do with the present safety of San Francisco's milk supply.

Fluid milk consumption in San Francisco in 1944 averaged about 70,620 gallons per day, or .729 pints per capita based on an estimated population of 775,000. The gallonage consumption represents an increase of 14 per cent over 1943. The per capita daily consumption figure of .729 pints is somewhat higher than is actually the case since it includes some milk

delivered to the armed forces which were not included in the population figure used.

Cream consumption was very much the same in 1944 as it was in 1943, although butter fat content dropped considerably since pastry cream has disappeared from the market except for medical dietary uses.

Fluid milk and cream was received, in 1944, from 647 dairy farms, of which 454 were grade "A" dairy farms and 193 were war emergency dairy farms qualified for the production of market milk. Of these 647 farms, 242 or 37. per cent shipped their milk directly to the pasteurizing plants, while 405 or 63 per cent shipped through country skimming and cooling plants.

In 1944 there were 14 pasteurization plants, all in the city of San Francisco. (One of these is now closed). There are 9 skimming and cooling plants in the country districts. Milk is shipped in from 15 counties adjacent to San Francisco and from the San Joaquin and Salinas valleys.

Altogether, 20,433 milk samples were taken in 1944, of which 12,511 were from producers, 4613 from pasteurizing plants, 1743 from retail milk vehicles, and the remainder from groceries, hotels, restaurants, etc. Inspections last year totalled 141,682.

About 50 per cent of the milk consumed in San Francisco comes from within 45 miles of the city and about 80 per cent within a range of 100 miles.

In addition to the somewhat over 20,000 milk samples taken by the Department of Health, the milk companies do a great deal of laboratory work. Of the 13 pasteurization plants operating at present, 3 have their own laboratories and the other 10 purchase laboratory service. Of the 9 skimming and cooling stations, one has its own laboratory and 2 others bring samples into their own laboratories. Before the war several other skimming stations had their own laboratory services.

The following table gives the analyses of milk and dairy product samples taken by the Department of Health in 1944.

The quality of the various kinds of milk, cream and dairy products as determined by chemical analyses and bacteriological examination is as follows, for 1944:-

	<u>Per Cent Milk Fat</u>	<u>Solids Not Fat</u>	<u>Bacteriological Colonies per Cubic Centimeter</u>
Raw milk received for pasteurization from war emergency dairy farms	4.02	8.62	10,000
Grade "A" raw milk received at skimming and cooling stations for grade "A" cream	4.07	8.62	9,000
Grade "A" raw milk received for pasteurization	4.07	8.70	11,000
Grade "A" pasteurized milk delivered retail	3.77	8.72	1,000
Grade "A" pasteurized milk delivered wholesale through groceries, delicatessens, hotels and restaurants	3.72	8.72	2,000
Goat milk raw for pasteurization	3.98	8.57	5,500
Goat milk pasteurized	3.87	8.36	1,000
War emergency raw cream for pasteurization	34.15	-	230,000
Grade "A" raw cream as received for pasteurization	38.10	-	74,000
Grade "A" pasteurized pastry cream	32.14	-	2,000
Grade "A" pasteurized table cream	19.76	-	3,000
Combined average of grade "A" pasteurized pastry cream and table cream	20.06	-	3,000
Half and half pasteurized	12.08	-	5,000
Chocolate milk and chocolate drink	1.88	-	3,000
Raw skim milk for pasteurization	-	-	27,500
Pasteurized skim milk	-	-	3,000
Ice cream and ice cream mix	10.58	-	9,000
Ices	1.28	-	2,000
Ice milk and ice milk mix	5.41	-	7,000
Orangeade	-	-	18
	117.		

The quality of the various kinds of milk, cream and dairy products as determined by chemical analysis and bacteriological examination is as follows, for 1941:-

Bacteriological Examination per Gallon	Solids Milk Per Cent	Fat Per Cent	Description
10.00	8.50	4.00	Raw milk received for pasteurization from the factory daily during
7.00	8.50	4.00	Grade "A" raw milk received at factory and cooling tank for Grade "A" cream
11.00	8.50	4.00	Grade "A" raw milk received for pasteurization
8.00	8.50	4.00	Grade "A" pasteurized milk delivered retail
8.00	8.50	4.00	Grade "A" pasteurized milk delivered wholesale through groceries, delicatessens, etc.
8.00	8.50	4.00	Grade "A" raw milk for pasteurization
1.00	8.50	4.00	Grade "A" milk pasteurized
20.00	-	3.50	For emergency raw cream for pasteurization
7.00	=	3.50	Grade "A" raw cream as received for pasteurization
8.00	=	3.50	Grade "A" pasteurized heavy cream
8.00	=	3.50	Grade "A" pasteurized table cream
3.00	=	3.50	Combined average of Grade "A" pasteurized heavy cream and table cream
8.00	=	3.50	Half and half pasteurized
7.00	=	3.50	Chocolate milk and chocolate drink
27.00	=	=	Raw skim milk for pasteurization
3.00	=	=	Pasteurized skim milk
8.00	=	10.00	Ice cream and ice cream mix
8.00	=	1.00	Ice
8.00	=	3.00	Ice milk and ice milk mix
18	=	=	Ice cream

The legal butter fat content is 3.4 per cent. Legal standards for solids not fats are 8.15 at the farm and 8.5 per cent for the finished product (after pasteurization). San Francisco does not permit a bacteriologic count of over 50,000 colonies per cubic centimeter for pre-pasteurized milk or more than 15,000 for pasteurized milk.

As indicated by this table, San Francisco's milk easily meets legal requirements. In the face of war conditions, we believe that these results, as shown in the table, are excellent. They would seem to indicate effective cooperation between the milk producers and companies and the Department of Health.

There are several factors which would seem to facilitate effective milk control and supervision in this area. First, and probably most important, is the fact that most of the dairy farms or ranches are fairly large, many if not most of them milking 100 or more cows. This means that the owners are substantial men carrying on dairying as their principal business, - not just a side line as is so often the case in many of our eastern or midwest farms. These men are, therefore, not only willing but capable of having modern equipment and of following proper methods of handling. The compactness of the milk shed, where 50 per cent of the milk comes from within 45 miles of the city, is another favorable factor, and the third factor is that universal pasteurization is accepted and has been in practice for some 12 years.

The 7 dairy inspectors work only in the country, inspecting farms and skimming and cooling stations. The 2 veterinarians do only animal inspections, and the 4 food inspectors work only in the city, inspecting pasteurizing plants, taking samples, and in inspecting the retail handling of milk within the city. The 2 veterinarians, now classed as dairy inspectors, should continue to do work which they are now doing but should be classified as veterinarians since their work is distinctly that of a veterinarian. There is, however, no good reason for having country and city inspectors separately classified. There should be but a single classification - that of milk inspector. This single classification would obviously permit greater flexibility and would make it possible to have a rotating service.

The present Chief of the Division (recommended to be a bureau) is not being paid a salary commensurate with the importance of the position and the excellence of his performance.

It is recommended:-

- (1).. THAT THE DIVISION OF DAIRY AND MILK INSPECTION BE CHANGED TO THE BUREAU OF DAIRY AND MILK CONTROL.

(2.) THAT THE PRESENT TITLE OF THE PERSON NOW IN CHARGE OF DAIRY AND MILK INSPECTION BE CHANGED TO THAT OF DIRECTOR OF THE BUREAU OF DAIRY AND MILK CONTROL AND THAT HIS SALARY BE INCREASED TO, FROM \$350.- \$400.

(3.) THAT VETERINARIANS NOW CLASSIFIED AS DAIRY INSPECTORS BE CLASSIFIED AS VETERINARIANS SINCE THEIR FUNCTIONS (ANIMAL INSPECTION) ARE DISTINCTLY THOSE OF A VETERINARIAN.

(4.) THAT INSPECTORS ENGAGED IN DAIRY AND MILK INSPECTION NOW CLASSIFIED AS DAIRY INSPECTORS AND FOOD INSPECTORS BE RECLASSIFIED IN A SINGLE CLASSIFICATION AS MILK INSPECTORS.

MEAT INSPECTION.

Meat inspection, in so far as it applies to ante-mortem and post-mortem examinations, is carried on by the Division of Abattoir Inspection consisting of the Chief Abattoir Inspector and 5 abattoir inspectors, all but one veterinarians.

Appropriations for the Division of Abattoir Inspection, for 1944-1945, are estimated to total \$25,360.00, or 3.3 cents per capita. Income for the preceding fiscal year totalled \$23,801.23, so that, as far as city-county tax funds are concerned, meat inspection cost but \$1,558.77, or 0.2 cents per capita.

The volume of work done by this division is today very much less than it was a few years ago because of the fact that now such a high per cent of meat is under federal inspection. (All meat companies engaged in interstate shipment are under Federal inspection).

Essentially, the work of this division consists of ante-mortem and post-mortem examinations of all animals whose meat is to be offered for human consumption. It is being capably carried on and no changes seem necessary.

PLUMBING INSPECTION.

Plumbing inspection for the City and County of San Francisco is carried on by the Division of Plumbing Inspection. The personnel of the Division includes the Chief, 7 plumbing inspectors, and a clerk-stenographer, making a total of 9. Although 4 of these inspectors are generally considered as plumbing inspectors and 3 as gas appliance inspectors, the ratio between the two functions is actually about even.

Appropriations for plumbing inspection for the present fiscal year total \$36,330.00, or 4.6 cents per capita. Income from fees, permits and licenses, for the past fiscal year, totalled \$26,120.50, which means that from tax funds plumbing inspection costs but \$10,209.50, or 1.3 cents per capita.

Plumbers, both master plumbers and journeyman plumbers, are examined by the Plumbing Board and licensed by the Director of Public Health on the recommendation of the Board. The Plumbing Board consists of 5 members, four being appointed by the Director of Public Health, the fifth being the Chief Plumbing Inspector who also is the Secretary of the Board. Two members' terms of office expire each year.

A person or company wishing to build a home, apartment, or other building with modern plumbing, electric, gas, heating, and other equipment must either personally or through a contractor apply to the following departments:-

1. To the Department of Public Works, its Central Permit Bureau, for -
 - (a.) A Building permit. Plans must be checked and approved by the departments of Fire, Health, and City Planning.
 - (b.) A permit for flues and chimneys.
 - (c.) A house number permit.
 - (d.) A permit to install a side sewer (if not already there) from the curb to the center of the street. (The City makes the installation but the property owner pays for it).
 - (e.) A permit to install a steam boiler.
2. To the Department of Electricity for a permit for all electrical wiring.
3. To the Department of Public Health for permits for the installation of all plumbing fixtures, roof drainage,

etc., and for all gas piping and gas appliances.

Large buildings, such as apartments, hotels, office buildings, etc. are inspected by plumbing inspectors a number of times as construction and the installation of plumbing and gas piping progresses. A simple dwelling has two plumbing inspections, one when plumbing which is to be enclosed is installed but not as yet concealed and the other when all fixtures are installed. Gas piping may have one or two inspections depending upon whether there is concealed piping.

There has been a good deal of discussion concerning the feasibility and desirability of transferring plumbing inspection from the Department of Health to the Department of Public Works. While there might be some advantage in doing this, mainly in terms of convenience to the individual or contractor who has to obtain permits, we believe that the disadvantages more than outweigh the advantages. While certain routine plumbing inspection activities could be transferred to another department, there are, nevertheless, some important public health aspects of plumbing, such as the possibility of cross connections and back siphonage, over which the Health Department should maintain supervision. Since all phases of plumbing inspection are now functioning effectively in a single unit, it would seem unwise to attempt to separate the routine from the public health aspects of the work.

It should also be borne in mind that all plumbing inspectors do some rodent control work and also a certain amount of mosquito control work.

It is therefore recommended:-

- (1.) THAT PLUMBING INSPECTION REMAIN A FUNCTION OF THE
DEPARTMENT OF HEALTH.

MEDICAL CARE.

In accordance with the proposed plan of organization the Medical Care Branch of the Department of Public Health would be in charge of an Assistant Director of Public Health and would include the San Francisco Hospital, the Laguna Honda Home, the Hassler Health Home, the Emergency Hospital Service, and the City Physicians' Service. The Assistant Director of Public Health should be a non-civil service position and residence should not be a prerequisite. He should have headquarters at the San Francisco Hospital.

It is therefore recommended:--

- (1.) THAT A NEW POSITION AS ASSISTANT DIRECTOR OF PUBLIC HEALTH, TO BE IN CHARGE OF THE MEDICAL CARE BRANCH OF THE DEPARTMENT OF PUBLIC HEALTH, BE ESTABLISHED WITH A SALARY OF \$500.-\$700. HE SHOULD HAVE HEADQUARTERS AT THE SAN FRANCISCO HOSPITAL.

This Assistant Director of Public Health should be a physician with exceptional training and experience in hospital administration. Additional experience in general public health administration is highly desirable.

THE SAN FRANCISCO HOSPITAL.

The San Francisco Hospital is a large city-county institution with what would be about 1574 beds if all the beds had been installed for which it was originally constructed. Actually a number of wards have been utilized, and properly so, for other purposes so that the hospital as it is used today has a bed capacity by construction (deducting - wards used for other purposes - wards at present closed and - wards which are unfinished) of 1043 beds. This number has been increased to 1166 beds for use during the war emergency. This crowding of wards (rather than the opening of additional wards) has been necessitated by war man power shortages. The bed capacity of the Hospital by present usage is 1166.

The following table gives the bed complement of the hospital by major services. Included in the Medical and Surgical bed capacity, referred to as the Main Building, is a ward of about 36 beds known as Ward 1. This Ward 1 is used for the hospitalization of municipal employees who are injured or taken ill while on duty. It is in effect the workman's compensation service for city employees.

Beds at the San Francisco Hospital

	Anticipated by Original Construction	: Present Use by Const- ruction.	: Present : Actual Use(War:be Emerg.)	: Add'l Beds* which could be used	: Total** Beds by Const.
Medical and Surgical	: 700	: 497	: 575	: 108	: 605
Obstetrics	: 150	: 60	: 75	: 30	: 90
Pediatrics	: 30	: 30	: 30	: --	: 30
Tuberculosis Unit	: 500	: 350	: 380	: 120	: 470
Isolation	: 90	: 54	: 54	: 36	: 90
Psychiatry	: 104	: 52	: 52	: 52	: 104
Total	: 1574	: 1043	: 1166	: 346	: 1389

*These are beds which could, if needed, be made available almost immediately if help were available.

** This figure represents the addition of the "Present Use by Construction" and the "Additional Beds which Could be Used", thus eliminating the overcrowding made necessary by War emergency use. Actually, this figure represents Column #1, "Anticipated by Original Construction" minus the wards which are used for other purposes and the two unfinished wards in obstetrics. If the two unfinished wards in obstetrics were completed, this would increase the bed capacity by construction to 1449. (Wards used for other purposes include one each for Central Supply, Red Cross Aide training, sewing room, social service, and tuberculosis clinic, making a total of about 195 beds).

The main building of the present hospital was opened in 1915 and the maternity-psychiatric building was added in 1937. It is not surprising, since much of the building and equipment is 30 years old, to find that there is a pressing need for repair and renovation and that a very considerable amount of equipment needs replacement. The list of

needed repairs and replacements is too long to include in this report. Perhaps the greatest needs are for a new large steam boiler, the modernizing of old boilers, a new steam turbine, and the replacement of worn out steam and water lines. Other important items include a new ammonia compressor and condenser, an additional elevator for the maternity building, repairs to hydrotherapy tank and equipment, the provision of a dressing and rest room for nurses in surgery, the moving of the dental room and the baby formula room to new locations, and the conversion of the section opposite the Mission Emergency into an observation ward. This list is but a sample of a long list of important needs which have developed over long years of usage without adequate annual provision for repair and replacement.

In addition to all the services customarily provided in a general hospital, the San Francisco Hospital has special units for Tuberculosis, Psychiatry, and the Acute Communicable Diseases. The hospital does not have a general out-patient service but it does maintain a follow-up clinic, for discharged in-patients who need periodic service after return to their homes and a pre-natal clinic for women who are to be delivered in the hospital. The tuberculosis clinic, while housed in the hospital, is actually conducted by the Tuberculosis Control Division of the Health Department. The hospital also houses and administers, in keeping with the plans and policies established by the Director of Emergency Hospital Service, the Mission Emergency Hospital.

While under the general supervision of the Director of Public Health, as are all other institutions in the Department of Public Health, the administration of the San Francisco Hospital is the function of the Superintendent and the Executive Medical Staff. Assisting in the administration of the hospital should be the Assistant Medical Superintendent (the position is at present vacant) and the Assistant Superintendent-Administrative (a newly recommended position).

The authority and responsibility for administration, including admission and discharge policies, but exclusive of medical care to patients, should be vested in the Superintendent.

The medical care of patients is and should be the responsibility of the medical staffs of the medical schools.

The coordination of the administration of the hospital and the provision of medical care for patients can and should be effected through regular meetings of the Executive Staff consisting of the superintendent and the chiefs of major services.

The basic plans and policies of the San Francisco Hospital should be established by the Director of Public Health, the Assistant Director of Public Health (when appointed), the Superintendent of the Hospital, and the Deans of the Medical Schools.

In considering the functions and administration of the San Francisco Hospital one should constantly bear in mind the fact that the institution has two fundamentally important functions:-

1. To provide adequate medical care to the poor people of this county.
2. To provide medical educational facilities which will maintain a high level, and develop an increasingly higher level, of medical competency.

One wonders whether the people of San Francisco realize that medical care of patients at its hospital is provided by the staffs of the medical schools without compensation from the city. The only compensation lies in the use of the facilities of the hospital for medical education.

Those responsible for city administration and the taxpayer should recognize two very important facts:-

1. That the poor of the city are receiving superior medical care, far better than that obtainable in most hospitals, without any direct compensation of the physicians who are responsible for providing that care.
2. That the medical educational program as augmented by the San Francisco Hospital constitutes a very important community asset in that it maintains a high level and continually raises the level of medical service available to the people as a whole, regardless of their economic status.

The medical schools should recognize two important facts:-

1. That the city is providing important educational facilities at considerable cost.
2. That they - the medical schools - should be sympathetic to those administrative policies which are designed to keep costs at a reasonable level as long as they do not seriously interfere with the basic essentials of medical education.

Both the city and the medical schools have a vital interest in the proper functioning of the San Francisco Hospital. The objectives of both groups are in no way incompatible, as is well evidenced by the fact that on the whole the present arrangement has worked and is working satisfactorily. In our opinion, the city profits most from the present program because it is securing a superior type of medical care for its poor which it could not procure in any other way and in that the program insures a generally higher level of medical care for all the people - regardless of financial status - than would otherwise be obtainable. These are assets of incalculable value. On the other hand, the medical schools do profit from the present arrangement since their primary objective of better medical education is thus effectively augmented.

At times, the city may be guilty of failing to appreciate the value of the benefits which it is obtaining and the medical schools may not always be as careful as they might be of incurring expenditures which may increase the cost of service without appreciably improving either the service to patients or the teaching program. Notwithstanding these occasional differences in point of view, the present program, as previously stated, is functioning remarkably well.

In order to present a clearer picture of the functioning of the Hospital, it may be well to describe briefly its personnel and major activities. Personnel is given in Table 2. Present employees of the San Francisco Hospital total 790. The budget includes 915, so that there are 125 vacancies, or 14 per cent. In addition to the personnel shown in the table, there are some 200 physicians, who make up the visiting staffs of the medical schools, and a corps of full-time laboratory technicians paid by the medical schools. About 100 visiting physicians give generously of their time while the other hundred give more limited service. While the internes, house officers and residents are paid by the health department, they are selected and supervised by the visiting medical staffs since their work at the hospital is still a part of their medical education.

Aside from the internes, house officers and residents, the only medical personnel paid by the health department are:-

The Superintendent, the Assistant Medical Superintendent (vacant), a full-time night superintendent, a full-time roentgenologist, a part-time medical admitting officer (stationed in Social Service), a part-time woman physician who examines female employees of the hospital and gives ambulatory care, and part-time physicians, one each, in orthopedics, psychiatry (was full-time but is now part-time), communicable disease, the blood bank, and an anesthetist (vacant). This makes a total of 4 full-time physicians, one of which positions is at present vacant, and

7 part-time medical positions with one vacancy. In addition, the health department employs 2 part-time dentists for the hospital.

The above mentioned personnel does not include the pre-natal and post-natal clinic nor the tuberculosis clinic. The pre-natal clinic has three part-time physicians employed by the health department one of whom is the director of the service. (The personnel of the tuberculosis clinic will be referred to in the section on Tuberculosis).

In several instances physicians paid for part time by the health department are also members of the visiting staff.

Apart from the medical care of patients, which is the sole responsibility of the medical staffs, the hospital is administered principally through the Superintendent; the Assistant Medical Superintendent (now vacant), the Senior Bookkeeper, who is actually functioning as the Assistant Superintendent-Administrative, the Chief Operating Engineer (actually functioning as the Superintendent of Maintenance and Mechanical Equipment for not only the San Francisco Hospital but Laguna Honda and Hassler as well), the Superintendent of Nursing, the Social Service Department and the Record Room.

The medical care of patients is excellent, far superior to that provided in most hospitals. The only question one might raise with respect to it lies in the failure to establish a clear cut and effective policy of admission and discharge. This looseness of intake and discharge policy has sometimes resulted in patients getting into the hospital who should not have been admitted and frequently in patients staying longer than was necessary. These difficulties are only partially due to a lack of definite intake and discharge policies; physical and other limitations have also played their part. For example, the Social Service Department does not function at night so that occasionally patients are admitted who are not eligible. If the Mission Emergency Hospital beds are full (there are only 12-14) and an accident occurs which results in a number of patients being brought in to the Mission Emergency, the patients who are already there, unless they can be discharged, have to be taken into the hospital. The establishment of an observation ward of about 40 beds, opposite Mission Emergency, would obviate both of the above limitations. Such an observation ward should save a very substantial number of hospital days of care.

Not infrequently a patient who is ready for discharge medically will not be discharged by social service because he or she has no place to go. The securing of a place to live for a person who is well enough to go home would not seem to be a function of the hospital, certainly not if

the person has to be kept in an acute hospital bed while a place is being sought. The patient should be discharged and expected to find a place for himself if he is able to pay for his own accommodation. If he is unable to pay he should be discharged and referred to the Department of Welfare. This procedure would doubtless save a good many days of unnecessary hospital care.

Another very important cause of prolonged stay in the San Francisco Hospital is the large number of cases which should be in the Laguna Honda Home. At present (Feb. 1, 1945) there are 162 cases who have been recommended for Laguna Honda who are still occupying hospital beds intended for the acutely ill.

An analysis of 115 of these cases, checked on January 26th, gives some very interesting information. Of these 115 cases, 34 or 30 per cent were recommended for Laguna Honda Home at the time they were admitted to the San Francisco Hospital. A total of 78 or 68 per cent were recommended for Laguna Honda within less than one month of their admission. An additional 21 or 18 per cent were recommended within from one to two months of their admission and only 16 or 14 per cent were in the hospital over 2 months before being recommended for transfer. Thus, it seems evident that a considerable number of patients get into the San Francisco Hospital who should have gone directly to Laguna Honda and most of those who turn out to be suitable for Laguna Honda are recommended for transfer within a comparatively short time after their admission to the hospital.

It is interesting to note that a very considerable proportion, probably over 40 per cent, of these patients, are on Old Age Assistance. Apparently very few are on relief.

How long do these patients stay in the San Francisco Hospital after they have been recommended for transfer? Of the 115 patients, whose analysis we have, who were in the hospital on January 26, 1945, a total of 31 or 27 per cent had, on that day, been there less than one week. A total of 51 or 44 per cent had been there less than one month and 64 or 56 per cent had been in the hospital more than a month after they had been recommended for transfer. Twenty eight or 24 per cent had been there for over 3 months and 7 or 6 per cent for more than 6 months. The following table gives the analysis of these cases in somewhat more detail. (See Page 130).

It is obviously more expensive to care for patients at the San Francisco Hospital than at the Laguna Honda Home and it would therefore seem that every possible effort should be made to increase the number of infirmary beds at Laguna Honda. We are unable to understand why 34

ANALYSIS OF 115 CASES RECOMMENDED FOR LAGUNA HONDA HOME

WHO WERE IN SAN FRANCISCO HOSPITAL ON JAN. 26, 1945.

Length of time between admission
to San Francisco Hospital and re-
commendation for Laguna Honda.

: Weeks.													
: At	:	:	:	:	:	:	:	:	:	:	:	: Over:	:
: same	: Under:	:	:	: 1-2	: 2-3	: 3-4	: 4-5	: 5-6	: 6-12	: 1	:	:	:
: time	: 1	: 1-2	: 2-4	:	:	:	:	:	:	: Yr.	:	Total	:
No.	: 34	: 9	: 9	: 26	: 21	: 8	: 4	: 1	: 2	: 1	:	: 115	:
Per Cent	: 29.6	: 7.8	: 7.8	: 22.6	: 18.3	: 7.0	: 3.5	: .8	: 1.8	: .8	:	: 100.0	:

Length of time in Hospital
since Recommendation for Laguna Honda.

Weeks.													
Months.													
: At	:	:	:	:	:	:	:	:	:	:	:	: Over:	:
: same	: Under	:	:	: 1-2	: 2-3	: 3-4	: 4-5	: 5-6	: 6-12	: 1	:	:	:
: time	: 1	: 1-2	: 2-4	:	:	:	:	:	:	: Yr.	:	Total	:
No.	: 31	: 3	: 17	: 17	: 19	: 13	: 6	: 2	: 6	: 1	:	: 115	:
Per Cent	: 27.0	: 2.6	: 14.8	: 14.8	: 16.5	: 11.3	: 5.2	: 1.8	: 5.2	: .8	:	: 100.0	:

ANALYSIS OF THE CASES REPORTED FOR TUBERCULOSIS

AND WERE IN THE HOSPITALS DURING THE YEAR 1900.

Length of time between admission
to San Francisco Hospital and
discharge for various reasons.

TABLE I.

Weeks.	At	Discharge	Death	Transfer	Other	Total
1	1	1	1	1	1	5
2	2	2	2	2	2	10
3	3	3	3	3	3	15
4	4	4	4	4	4	20
5	5	5	5	5	5	25
6	6	6	6	6	6	30
7	7	7	7	7	7	35
8	8	8	8	8	8	40
9	9	9	9	9	9	45
10	10	10	10	10	10	50
11	11	11	11	11	11	55
12	12	12	12	12	12	60
13	13	13	13	13	13	65
14	14	14	14	14	14	70
15	15	15	15	15	15	75
16	16	16	16	16	16	80
17	17	17	17	17	17	85
18	18	18	18	18	18	90
19	19	19	19	19	19	95
20	20	20	20	20	20	100

Length of time in hospital.

TABLE II.

TABLE III.

Weeks.	At	Discharge	Death	Transfer	Other	Total
1	1	1	1	1	1	5
2	2	2	2	2	2	10
3	3	3	3	3	3	15
4	4	4	4	4	4	20
5	5	5	5	5	5	25
6	6	6	6	6	6	30
7	7	7	7	7	7	35
8	8	8	8	8	8	40
9	9	9	9	9	9	45
10	10	10	10	10	10	50
11	11	11	11	11	11	55
12	12	12	12	12	12	60
13	13	13	13	13	13	65
14	14	14	14	14	14	70
15	15	15	15	15	15	75
16	16	16	16	16	16	80
17	17	17	17	17	17	85
18	18	18	18	18	18	90
19	19	19	19	19	19	95
20	20	20	20	20	20	100

or 30 per cent of patients who were recommended for Laguna Honda at the very time of admission were ever admitted to the San Francisco Hospital. Having been judged at the very outset as Laguna Honda patients, why shouldn't they have been placed on the waiting list for Laguna Honda rather than admitted to an institution which is essentially for the care of the acutely ill?

This is one of the problems which calls attention to the need for an Assistant Director of Public Health to have general supervision over the entire medical care program.

The following table (Page 132) gives the average days of stay in the hospital for various types of cases in the San Francisco Hospital and in 4 other hospitals.

This table indicates clearly that the average days of stay in the San Francisco Hospital for most types of cases exceeds that of other hospitals except for medicine and surgery in which the average stay at hospitals C and D is higher than at San Francisco.

Some of the reasons for unnecessary days of hospitalization have already been mentioned. Perhaps the most important reason is that no one person is responsible for discharging patients and there is no real pressure on anyone to make the decision as to when a patient can safely be discharged. It is believed that the authority and responsibility for discharging patients should rest with the Superintendent and Assistant Medical Superintendent. This does not of course imply that the Superintendent or Assistant Superintendent would personally discharge each patient. Neither does it mean that in general the wishes of the medical staff with respect to the discharge of individual patients should be abrogated. It does mean that the Superintendent or Assistant Superintendent should urge those responsible for making discharges to make decisions as to when patients may be discharged. It is firmly believed that this simple method of provoking a decision would result in a substantial saving in days of hospital care.

Although there are rare instances in which a patient is kept an unnecessarily long time for teaching purposes, there is no evidence that the teaching program is contributing in any substantial way to hospital overstay.

If the several suggestions as to methods of reducing the length of hospital stay are put into effect, and result in the average stay per patient being reduced by one and one-half days, the saving would, theoretically at least, be over \$193,000. per year. (Based on 14340 annual discharges and \$9.00 per day as the cost of care).

AVERAGE DAYS OF STAY IN

SAN FRANCISCO AND SEVERAL OTHER HOSPITALS.

	(1)			(2)			(3)			(4)	(5)
	San Francisco			A			B			C	D
FOR:--	A	B	Tot.	Teaching	Private	Teaching	Private	Teaching	Private		
Medicine	17.1	16.9	16.7	17.8	8.1	16.5	11.9	20.3	19	+	
Surgery	20.0	17.2	18.3	17.9	12.4	12.9	9.6	26.7	19	+	
Obstetrics	9.5	9.9	9.7	6.6	8.7	9.2	8.7	7.0			
Gynecology	16.4	18.7	17.4	10.0	8.5	9.5	9.7				14
Eye, Ear, Nose & Throat	14.1	10.9	12.2			5.7	5.6	1.7			11.0
Eye				9.7	7.2						
Nose and Throat				4.1	5.7						
Genito-Urinary				14.0	13.9						
Urology	26.3	27.8	27.0			16.0	13.4				19
Orthopedics	38.0	35.8	33.4	10.0	9.5	16.4	14.1	48.8	19	+	
Pediatrics	12.0	12.0	12.0	11.8	7.2	14.6	7.9	4.9			
Traumatic Surgery	20.1	19.0	19.4								33
Tumors	31.9	28.1	29.9								47

(1) Period of July 1, 1942-June 30, 1943 A - One service, B the other. The total includes Ward 1, which is not included in either A or B.

(2) Based on the months of March, April and May, 1944.

(3) Based on fiscal year 1943-1944.

(4) Based on 1944.

(5) Based on 1943.

The Superintendent of the Hospital is doing a creditable job under difficult conditions. An Assistant Medical Superintendent is needed greatly. The job of running an institution of that size and with such a wide variety of services needs more than one full-time medical man in addition to an assistant to aid in the supervision of the non-medical aspects of the hospital. Some medical person in an authoritative position has to be on duty in the office practically all the time, which means that without an assistant the superintendent is not able to keep in as close personal touch with the various services of the hospital as would be desirable and helpful to good administration. Man power shortages, the inability to obtain skilled help, and the rapid turnover of personnel, particularly in certain categories such as orderlies and porters, add to the difficulty of administering a large hospital in this war period.

The greatest difficulty in administration, however, lies in the failure to define clearly authorities, responsibilities and relationships. As previously stated, the broad plans and policies for the hospital should be established by the Director of Public Health, the Assistant Director of Public Health (when appointed), the Deans of the Medical Schools, and the Superintendent and should be clearly understood by all concerned. The day to day administration of the hospital, in keeping with established plans and policies, should be the responsibility of the Superintendent and the Executive Medical Staff. Neither the Director of Public Health nor the Deans of the Medical Schools should be members of the Executive Medical Staff since they have already established the plans and policies for the hospital and the day to day administration should be the responsibility of the group who are actually in the hospital and therefore closest in touch with its problems. To put the case very frankly, there is no hope for truly effective administration of the San Francisco Hospital, or, for that matter, of the entire Department of Public Health, unless the Director of Public Health is willing to delegate authority and responsibility to the Assistant Director of Public Health (when appointed), to the Superintendent (and others in administrative positions), and give backing and support to decisions reached as long as they are not inconsistent with established plans and policies. Effective team-work is essential to good administration and one can not expect team-work unless persons are given definite assignments and are given the opportunity of carrying out those assignments.

As already pointed out, the position of Assistant Medical Superintendent should be filled at the earliest possible time as a necessary means of enabling the Superintendent to have a better personal knowledge of how the various activities of the hospital are functioning.

The Senior Bookkeeper is actually functioning as the Assistant Superintendent-Administrative and is, under the general supervision of the

Superintendent, assuming the major administrative responsibility for the wide variety of largely non-medical functions of the hospital. His position should be reclassified to that of Assistant Superintendent-Administrative and he should be paid a salary commensurate with the responsibilities and importance of the position.

Studies undertaken and completed by this individual, oncosts and methods of doing things, have already resulted in substantial savings. Other studies now under way or planned, notably in the serving of meals, in laundry service, and in major mechanical operations, give promise of effecting still further economies and improvement of service. The addition of two well trained bookkeepers would greatly facilitate not only the completion of these studies but the continuous initiation of cost and administrative studies which give promise of improving service at less cost.

The nursing service is obviously one of the most important and basic functions of the entire hospital. No hospital can function effectively without an adequate staff of well trained nurses with well qualified supervisors. The hospital employs only registered nurses.

Nursing personnel of the hospital, exclusive of the tuberculosis clinic consists of the Superintendent of Nursing, 4 Assistant Superintendents, 2 Night Supervisors, 3 Nursing Instructors, 26 Operating Room Nurses, and 165 Institutional Nurses, making a total of 201. The five anesthetists, who are nurses, are not responsible to the Superintendent of Nursing and are not included in these figures. The budget also includes a small amount for special nurses as needed. The numbers of nurses just quoted constitute the numbers which are allowed in the budget. The actual number on duty (as of Dec. 15, 1944) presents quite a different picture. There is one vacancy among the Head Nurses, 3 vacancies in Operating Room Nurses, and 71 unfilled positions in Institutional Nurses. Thus altogether, instead of 201 nurses, as allowed in the budget, the hospital is functioning with but 126 nurses, which constitutes a staff which is 37.3 per cent undermanned.

The Superintendent of Nursing, with her staff, is to be congratulated on having maintained as reasonable an amount of and distribution of nursing as has been provided with such a serious shortage of personnel. In spite of criticisms of inadequacy of nursing service, and it is inevitable that it would be inadequate with such an acute man power shortage, the nurses at the San Francisco Hospital have done and are doing yeoman duty. Without careful planning and supervision and considerable personal sacrifices the service could not be maintained.

Institutional nurses in war time are entitled to just as much admiration and praise for their contribution to the war effort as are their brothers and sisters who are serving in the armed forces.

Even with this careful planning and personal sacrifice, the job of providing nursing service in the San Francisco Hospital could not have been done without the splendid and untiring efforts of the some 90 Red Cross Nurses Aides who have served and are serving the hospital. Credit should also be given to the affiliated nurses from the various nurses' training schools for the splendid help which they have given. (These nurses in training, about 85 at a time, affiliate with the San Francisco Hospital for from 6 weeks to 6 months each),

From time to time there has been a good deal of discussion as to the advisability or inadvisability of establishing a training school for nurses at the San Francisco Hospital. Without discussing the question in detail, we believe that it would be inadvisable to establish such a training school for nurses. The two most important reasons for expressing this belief are:-

1. To establish a training school for nurses at the San Francisco Hospital would involve a number of personnel additions as well as structural changes which would be found very difficult if not impossible to make, at least for the present time.
2. The establishment of a training school would make it impossible to accept any, or any appreciable number of, nursing affiliates from other training schools. The affiliation of nurses at the San Francisco Hospital is of very real value to the training schools for nurses since the affiliates can get at this hospital valuable training and experience in services which many of the other hospitals do not have (communicable diseases, tuberculosis and psychiatry, for example), and from the more selfish standpoint of the hospital itself the hospital has the constant service of about 85 nurses in training. In considering the relative merits of the service which these 85 nurses in training provide as compared to the value of the service which might be given by nurses in training if the hospital maintained its own training school, several facts should be borne in mind:

(a.) The proposed training school could only take about 100 students. About one-third of the time of training a nurse is devoted to classroom instruction which constitutes a cost to the hospital and contributes nothing to the actual nursing service to patients.

(b.) The approximately 85 nurses who are constantly at the San Francisco Hospital have already had the major portion of their classroom instruction and are therefore immediately assets rather than liabilities to the nursing service of the hospital.

Every effort should be made by both the hospital and the central office to minimize the amount of clerical work in the nursing office. The nursing office should have a stenographer.

The Chief Operating Engineer at the hospital has direct charge of all engineering functions and the maintenance of all mechanical equipment at not only the San Francisco Hospital but also at the Laguna Honda Home, the Hassler Health Home and, to a lesser extent, for the Emergency Hospital Service. That such a job is more than one man can handle adequately is evident. There should be a Chief Operating Engineer exclusively for the San Francisco Hospital and a second Chief Operating Engineer for the other institutions. The need for such an engineer for the San Francisco Hospital alone becomes all the more apparent when one considers the fact that much of the equipment at that institution is 30 years old.

The Social Service Division of the hospital consists of a senior social service worker and 18 social workers. A second senior social service worker, not included in the total or the discussion, is on military leave. The senior and 4 other social workers have had a year's special training in social work; the others have had experience but no training. None have had special medical social work training. Only two of the entire group of social workers do any appreciable amount of work outside of the hospital itself. One devotes himself largely to the investigation of the economic status and conditions of male applicants including applicants for the Laguna Honda Home, and the other to field investigations of women patients including Laguna Honda. The greater part of the social worker's time is devoted to the determination of eligibility, probably over 80 per cent of her time going into this phase of the work. While some efforts are made to adjust home conditions to the needs of the patient, there is no real case work program. A limited but sound case work program might be undertaken by substituting two well trained medical social workers for two of the present staff.

The social service work at the hospital is criticized more than any other service in the hospital and is probably the weakest phase of its work. At best, the job of the social worker where eligibility is the dominant factor is a difficult one. The service at the San Francisco Hospital has the reputation of being particularly "hard-boiled". We believe that the Social Service division is given altogether too much authority in determining admissions to and discharges from the hospital. The question of deciding the eligibility of a patient should rest on

the findings of both the social service worker and the physician but we believe that the final decision on all doubtful or borderline cases should be the responsibility of the physician and not of the social worker.

Activities of the social workers in relation to tuberculosis have, in our opinion, interfered with the proper functioning of the tuberculosis control program. Frequently patients have been so worried and upset by the social worker as to seriously interfere with the effectiveness of treatment. One should remember that tuberculosis is a communicable disease and that the care of the case is only one of the two important reasons for insisting on hospitalizations; the other is the protection of his family and the community. While many people can afford the cost of limited hospital care, very, very few can afford the cost of the long term care needed for tuberculosis. The few who can readily afford private care will not be found in a public tuberculosis clinic or as applicants for public hospital care. We do not believe that social service need enter the picture as far as tuberculosis is concerned except to determine whether or not the person would be eligible from the standpoint of residence or jurisdiction; that is, whether the case belongs to this county or some other county or state, or is perhaps eligible for care by the Veteran's Administration or other agency. Arrangements for hospitalization in terms of the family and home can be made (as they are now) by the public health nurse.

Cases of communicable disease which are hospitalized in the Isolation Unit likewise need no social service except to determine the question of residence. Here the situation is even more clear cut than it is in tuberculosis. In the great majority of instances the communicable disease case is hospitalized essentially for the protection of the public health, only secondarily for the care of the patient. Since in many instances the patient is hospitalized against his wish it would probably be impossible to require the payment of his hospital bill. Cases of communicable disease who come from other cities or counties and are hospitalized at the San Francisco Isolation Unit should, as is now required, have a statement of authorization signed by the health officer of the area from which they come which obligates the city or county, in which the patient resides, to pay the hospital bill. As in the case of tuberculosis, home arrangements would be handled by the public health nurse.

That some changes in the present social service program are desirable seems evident. In addition to the suggestions already made, there appear to be three possibilities:-

1. To establish a medical social work office, quite apart from the present social service, with at least two well trained medical social workers as a nucleus to develop a limited but sound case work program.

2. To replace two of the present staff of social workers with two well trained medical social workers and thus develop a limited but sound case work program.
3. To admit that the social service division is essentially an eligibility determining service and recognize its inability to carry on a case work program.

We are inclined to think that the second of these three courses is the most feasible.

Civil Service qualifications for social workers do not insure the recruitment of adequately trained persons.

The Record Room is in charge of a statistician who is also a qualified medical record librarian. There is one other person classified as a statistician who is also a qualified medical record librarian. The remainder of the personnel consists of 4 general clerks, 1 clerk-typist, an office assistant, and the half-time service of a clerk-stenographer, making a total for the Record Room of $8\frac{1}{2}$. Of this number only two have had training in the field of medical records.

The work of the Record Room is capably administered and well planned, but there are two difficulties which interfere with its effectiveness:-

1. Records of patients discharged do not uniformly go directly to the record room immediately after discharge. At present there are some 2500 patient records the locations of which are unknown. In case of suit or other legal procedure the failure to be able to locate records might prove very embarrassing. All patient records should go to the record room immediately after the discharge of the patient (within a specified number of hours). Physicians or others who may need such records later may procure them from the record room but should be required to sign for them so that their location is known.
2. The lack of a sufficient number of trained personnel.

At present there are two medical record librarians.

"The Manual for Medical Record Librarians" states that there should be one medical record librarian for each 2000 annual discharges. In the fiscal year 1942-43 the San Francisco Hospital had 14621 discharges which would mean that there should be 7 medical record librarians for such a case load. The addition of two medical record librarians would help the situation very materially.

The Isolation Unit at the San Francisco Hospital was originally constructed as a unit of 120 beds. One ward of 30 beds is used for pediatrics and another ward of 36 beds is closed (but could be opened if necessary) thus making the present bed capacity for the acute communicable diseases 54. This number of beds seems ample to take care of the normal demand. The Unit is administered by a part-time physician. No changes seem necessary. (See recommendation concerning discontinuance of billing communicable disease patients).

The Psychiatric Unit is 104 beds by construction but two wards are closed, making the present bed capacity 52 beds. The psychiatric service is in charge of a part-time psychiatrist. The service consists largely of holding patients a rather short period of time (ordinarily not over 20 days and the average stay is about 6 days) pending a decision as to commitment to a mental institution or discharge. There is no real psychiatric treatment. Commitments are made by the Lunacy Commission which, strangely enough, does not have included in its membership a single psychiatrist. Many, if not most of the cases which come into the Psychiatric Unit are not susceptible of psychiatric treatment; those who are have to be sent to one of the state mental institutions which is equipped to give real psychiatric service.

There is also a Detention service in charge of a Detention Steward. This service consists merely in temporarily housing patients for the Lunacy Commission pending their transfer. These patients are not entered as hospital patients and are not treated by the staff. If they need treatment they must be transferred to the psychiatric service before treatment can be given. It would seem highly desirable to change the Psychopathic Ordinance so as to obviate this apparently unnecessarily cumbersome service.

In common with most other communities San Francisco has a dearth of facilities for psychiatric treatment. There are about 100 beds at the Langley-Porter, some 20 beds at Stanford, and the 52 beds at the Psychiatric Unit of the San Francisco Hospital where, however, psychiatric treatment is not provided. In addition, there are two private institutions, one fairly large with about 150 beds which does provide psychiatric treatment, the other a small sanatorium which furnishes largely custodial care.

That there is a need for more psychiatric treatment facilities seems certain. As the war comes to a close, and perhaps even before that, rehabilitation will become a problem of tremendous importance. Mental health will doubtless be an important aspect of this problem. As a means of assisting in providing additional facilities, it would seem wise at the

earliest opportunity to open the two closed wards in the Psychiatric Unit and staff them to provide modern psychiatric diagnostic and treatment service for those who seem likely to benefit from such treatment. These wards should be kept entirely separate from the present psychiatric wards (since the present wards are of necessity used for patients most of whom are not amenable to real psychiatric treatment) and be administered by the psychiatric staffs of the medical schools.

There has been some discussion as to the feasibility and desirability of permitting physicians outside the staffs of the Medical Schools to care for patients in the wards. This would seem to be neither necessary nor desirable. There are a number of reasons for reaching this decision but perhaps the most important one is the difficulty in deciding who is a psychiatrist. Any physician can call himself a psychiatrist but few have any real knowledge of modern psychiatry. The Medical Schools would seem to be better fitted than any other agencies to decide who was equipped to render psychiatric service. The number of physicians who are really qualified to render service in this special field is small and it seems highly probable that any physician with real qualifications as a psychiatrist could obtain an appointment from one or another of the Medical Schools so that he could care for patients in these psychiatric wards. The question of providing facilities for the care of private cases is quite another problem. If the demand for private care is sufficient, it would seem feasible for those interested to provide their own facilities.

PRENATAL AND POSTNATAL SERVICES.

As previously stated, the only prenatal and postnatal clinic service provided by the Department of Public Health is a clinic at the San Francisco Hospital for women who are to be delivered at the hospital.

The clinic is manned by three part-time physicians (all obstetricians), one of whom, a particularly well qualified obstetrician, is the Director of the Service.

In the year ending June 30th, 1944, there were 100 prenatal clinic sessions serving 472 women. Visits to the clinic totalled 2682 or an average of approximately 5.7 visits per patient. Although the information as to when in pregnancy the patient first came to the clinic is entered on the individual case record, there has been no tabulation of this data. The average number of visits per patient, however, is presumptive evidence that either the patients were irregular in their attendance or did not come to clinic until rather late in pregnancy. There were 49 postnatal

clinic sessions, with a total attendance of 283.

During the fiscal year, July 1, 1943 to June 30, 1944, there were 753 admissions to the obstetrical wards of the San Francisco Hospital. Of this number, 435 or 57.8 per cent had attended the prenatal clinic.

While there is no criticism of the service at the clinic, a more careful analysis of the service would answer the important question as to how early or late in pregnancy patients began clinic care. One question which might be raised is whether or not there is a need for additional prenatal and postnatal Department of Health clinic service. As will be noted in the section on "Maternal and Child Health" it has been recommended that prenatal and postnatal service be included in the overall planning of that bureau.

It is recommended that:-

- (1.) NO CHANGES IN THE PLAN OF ADMINISTERING THE SERVICES OF THE SAN FRANCISCO HOSPITAL BE MADE WHICH WOULD SERIOUSLY INTERFERE WITH THE BASICALLY IMPORTANT MEDICAL CARE AND MEDICAL EDUCATIONAL FUNCTIONS OF THE INSTITUTION.
- (2.) THE BASIC POLICIES GOVERNING THE FUNCTIONS AND RESPONSIBILITIES OF THE SAN FRANCISCO HOSPITAL SHOULD BE ESTABLISHED BY THE DIRECTOR OF PUBLIC HEALTH, THE ASSISTANT DIRECTOR OF PUBLIC HEALTH (MEDICAL CARE BRANCH) (WHEN APPOINTED), THE DEANS OF THE MEDICAL SCHOOLS AND THE SUPERINTENDENT OF THE HOSPITAL.

Regular meetings should be held to determine broad plans and policies and once agreed upon they should be written out and made known to the Hospital Executive Staff and all others concerned. The importance of this group planning will become even more important if and when some prepaid medical care program is adopted.

- (3.) THE ADMINISTRATION OF THE HOSPITAL IN KEEPING WITH ESTABLISHED PLANS AND POLICIES SHOULD BE THE RESPONSIBILITY OF THE EXECUTIVE STAFF CONSISTING OF THE SUPERINTENDENT AND THE CHIEFS OF MAJOR SERVICES.

Neither the Director of Public Health nor the Deans of the Medical Schools should be members of this Executive Staff.

The Executive Staff should hold regular meetings at least once a month. Major decisions should be written and be made clearly understandable

to all concerned. Additional members of the medical staffs should be invited to attend and participate in discussions of special subjects.

- (4.) THE SUPERINTENDENT OR ASSISTANT MEDICAL SUPERINTENDENT SHOULD HAVE THE AUTHORITY TO MAKE DECISIONS WITH RESPECT TO BOTH ADMISSIONS AND DISCHARGES.

It is fully realized that this authority could be (but we don't think that it would be) abused to the extent of interfering with the program of medical teaching. This recommendation does not contemplate the misuse of such authority. It is intended to place the actual authority where it rightfully belongs but primarily it is aimed to establish a clear cut and definite method of urging those responsible for making discharges to make decisions as to when patients may be discharged. We are confident that this simple method of provoking a decision will result in a considerable saving in days of hospital care.

Since it seems far easier to get a patient into the hospital (particularly at night when social service is not functioning) than it is to get him out once he is in, it is recommended:-

- (5.) THAT AN OBSERVATION WARD OF APPROXIMATELY 40 BEDS BE ESTABLISHED IMMEDIATELY ADJACENT TO THE MISSION EMERGENCY HOSPITAL.

In accordance with this plan the physician in charge of admissions at the Mission Emergency entrance would see the patient and make a decision as to whether the case could be cared for as an Emergency Hospital case (a case which, after emergency treatment, could be transferred to his own physician, to another hospital, or to his home) or whether it should be placed in the Observation Ward pending its possible admission as an inpatient of the hospital.

The establishment of such an Observation Ward would facilitate administration in at least four ways:-

1. It would prevent the occupancy of emergency beds by patients who may need inpatient care.

2. When a serious emergency occurs necessitating the use of a number of beds, it would prevent the necessity of transferring to inpatient care patients who were then occupying emergency hospital beds.
3. It would permit a longer period of time in which to determine the clinical need for inpatient care.
4. It would permit the determination of eligibility by social service before the patient was admitted to inpatient hospital care.

The development of an Observation Ward might involve the employment of an additional house officer or resident.

(6.) THAT PHYSICIANS EMPLOYED BY THE DEPARTMENT OF HEALTH BE GIVEN, BY THE CITY, ADEQUATE PROTECTION AND INSURANCE AGAINST MALPRACTICE AND OTHER SUITS WHICH MIGHT BE BROUGHT AGAINST THEM.

(7.) THAT PATIENTS WHO ARE MEDICALLY READY FOR DISCHARGE BE:
(a) DISCHARGED TO THEIR OWN RESOURCES IF THEY ARE ABLE TO PAY FOR THEIR OWN ACCOMMODATIONS, (b) DISCHARGED AND REFERRED TO THE DEPARTMENT OF WELFARE IF THEY ARE UNABLE TO FINANCE THEIR OWN ACCOMMODATIONS.

(8.) THAT ALL THE ACTIVITIES OF THE SOCIAL SERVICE DIVISION OF THE HOSPITAL FOR ADMISSION TO OR DISCHARGE FROM THE TUBERCULOSIS UNIT OF THE SAN FRANCISCO HOSPITAL BE DISCONTINUED EXCEPT FOR THE DETERMINATION OF WHETHER THE PROSPECTIVE PATIENT IS LEGALLY (NOT FINANCIALLY) ELIGIBLE FOR CARE BY THIS COUNTY, THE VETERAN'S ADMINISTRATION

(8.) OR OTHER AGENCY, OR SOME OTHER COUNTY, STATE, OR COUNTRY.
(Cont.)

Patients found to be legally eligible for care by this county (regardless of financial status) would, in accordance with this plan, be referred to the public health nurse of the Department of Health who would make home visits to make the necessary arrangements for hospitalization. Upon discharge, whenever possible well before discharge, the public health nurse would be notified of the patient's contemplated return home in order that she may assist in seeing to it that proper arrangements are made for such return.

(9.) THAT, UNLESS IT IS OBVIOUS THAT THE PATIENT HAS AMPLE FUNDS, NO ATTEMPT BE MADE TO BAR A TUBERCULOSIS CASE OR OTHER COMMUNICABLE DISEASE CASE FROM RECEIVING PUBLIC HOSPITAL OR OTHER INSTITUTIONAL CARE ON THE BASIS OF FINANCIAL OR ECONOMIC STATUS, PROVIDED SUCH PERSON IS OTHERWISE ELIGIBLE FOR SUCH CARE AND THAT NO ATTEMPT BE MADE TO COLLECT FUNDS FROM SUCH PATIENT TO HELP DEFRAY THE EXPENSE OF HIS OR HER CARE.

The preceding two recommendations are made in the belief:-

- (a) That the activities of the social service division of the hospital, except for deciding the legal eligibility, quite apart from financial status, of the patient, serve no useful purpose and, on the contrary, tend to interfere with the recovery of the patient by worrying him and upsetting him emotionally.
- (b) That an extremely small per cent (probably not more than 1 or 2 per cent) of all tuberculosis cases can bear the expense of the prolonged care (usually accompanied by a cessation of income) which tuberculosis demands and that almost none of the few who could afford private care would find their way into a public clinic or public hospital.

It is further recommended:-

- (10.) THAT SOCIAL SERVICE ACTIVITIES FOR COMMUNICABLE DISEASE CASES BE DISCONTINUED EXCEPT TO DETERMINE THE RESIDENTIAL ELIGIBILITY OF PATIENTS.

Patients from other counties should be, as they are, expected to have a written authorization from the health officer of the city or county in which they reside which obligates such city or county to pay the hospital bill.

- (11.) THAT SOCIAL SERVICE AT THE SAN FRANCISCO HOSPITAL PURSUE ONE OR ANOTHER OF THE FOLLOWING COURSES:

(a) ESTABLISH A MEDICAL SOCIAL WORK OFFICE, QUITE APART FROM THE PRESENT SOCIAL SERVICE, WITH AT LEAST TWO WELL TRAINED MEDICAL SOCIAL WORKERS AS A NUCLEUS TO DEVELOP A LIMITED BUT SOUND CASE WORK PROGRAM.

(b) REPLACE TWO OF THE PRESENT STAFF OF SOCIAL WORKERS WITH TWO WELL TRAINED MEDICAL SOCIAL WORKERS AND THUS DEVELOP A LIMITED BUT SOUND CASE WORK PROGRAM.

(c) ADMIT THAT THE SOCIAL SERVICE DIVISION IS ESSENTIALLY AN ELIGIBILITY DETERMINING SERVICE AND RECOGNIZE ITS INABILITY TO CARRY ON A CASE WORK PROGRAM.

- (12.) THAT CIVIL SERVICE QUALIFICATIONS FOR SOCIAL WORKERS BE REVISED UPWARDS SO AS TO INSURE THE RECRUITMENT OF PROPERLY QUALIFIED PERSONS FOR SUCH POSITIONS.

- (13.) THAT INTERNES, HOUSE OFFICERS AND RESIDENTS, SINCE THEY ARE STILL UNDERGOING MEDICAL EDUCATION, SHOULD HAVE THEIR HOURS AND WORKING CONDITIONS DETERMINED BY THE MEDICAL STAFFS OF THE SAN FRANCISCO HOSPITAL AND NOT BY CIVIL SERVICE.

Civil Service, the Medical Schools, and Hospitals should consider jointly the adjustment of salaries of internes, house officers and residents so that there will be more uniformity of remuneration for these positions in this area.

- (14.) THAT THE POSITION OF SUPERINTENDENT OF THE SAN FRANCISCO HOSPITAL BE PLACED AS SOON AS POSSIBLE ON A PERMANENT BASIS.

- (15.) THAT A DETERMINED EFFORT BE MADE TO FILL THE POSITION OF ASSISTANT SUPERINTENDENT OF THE SAN FRANCISCO HOSPITAL.

- (16.) THAT A NEW POSITION AS ASSISTANT SUPERINTENDENT-ADMINISTRATIVE BE ESTABLISHED FOR THE SAN FRANCISCO HOSPITAL AND THAT IT BE FILLED BY THE PERSON NOW OCCUPYING THE CLASSIFICATION OF SENIOR BOOKKEEPER.

Ordinarily it is not the policy of your surveyors to recommend any particular person for a given position but the savings which the aforementioned individual has effected for the hospital and the potentialities for further savings seem to warrant an exception in this case.

- (17.) THAT UNTIL SUCH TIME AS THE ASSISTANT DIRECTOR OF PUBLIC HEALTH (IN CHARGE OF THE MEDICAL CARE BRANCH) IS APPOINTED, THE DIRECTOR OF PUBLIC HEALTH

- (17.) DELEGATE THE AUTHORITY AND RESPONSIBILITY FOR
(Cont.) THE ADMINISTRATION OF THE SAN FRANCISCO HOSPITAL,
IN KEEPING WITH PLANS AND POLICIES ESTABLISHED BY
THE DIRECTOR OF PUBLIC HEALTH, THE SUPERINTENDENT
AND THE DEANS OF THE MEDICAL SCHOOLS, TO THE
SUPERINTENDENT OF THE HOSPITAL.
- (18.) THAT THE DIRECTOR OF PUBLIC HEALTH GIVE BACKING
AND SUPPORT TO DECISIONS, MADE BY THE SUPERINTENDENT
OF THE HOSPITAL, WHICH ARE IN KEEPING WITH ESTAB-
LISHED PLANS AND POLICIES.
- (19.) THAT, IN KEEPING WITH GENERALLY ESTABLISHED PLANS
AND POLICIES AND WITH DECISIONS REACHED FROM TIME
TO TIME BY THE MEDICAL EXECUTIVE STAFF OF THE
HOSPITAL, THE MEDICAL STAFFS SHALL BE RESPONSIBLE
FOR AND BE THE FINAL JUDGES OF WHAT MEDICAL CARE
IS GIVEN TO PATIENTS.
- (20.) THAT THE LABORATORIES SHALL PREPARE ANNUAL BUDGETS
AND SHALL, AFTER SUCH BUDGETS ARE DECIDED UPON AND
APPROVED, BE EXPECTED TO KEEP WITHIN THE QUARTERLY
ALLOWANCES OF SUCH BUDGETS. ANTICIPATED OVER-
EXPENDITURES SHOULD NOT BE INCURRED WITHOUT THE
APPROVAL OF THE SUPERINTENDENT.

Some such arrangement seems necessary in order to
prevent possible inroads, by over-expenditures by the laboratories,
into other important supply and maintenance appropriations.

- (21.) THAT IMMEDIATELY AFTER DISCHARGE THE PATIENT'S CASE RECORD BE SENT TO THE RECORD ROOM.

Persons needing such records subsequent to discharge can obtain them by signing them out from the record room. The above recommendation is made because at the present time there are some 2500 records of discharged patients missing from the Record Room without any knowledge of where they are. The inability to locate a record in case of a suit might present a difficult and embarrassing situation.

- (22.) THAT TWO WELL TRAINED MEDICAL RECORD LIBRARIANS BE ADDED TO THE STAFF OF THE RECORD ROOM.

- (23.) THAT AT THE EARLIEST POSSIBLE OPPORTUNITY THE HOSPITAL BE THOROUGHLY CLEANED AND RENOVATED.

- (24.) THAT THE TUBERCULOSIS CONTROLLER BE RESPONSIBLE FOR THE ADMISSION OF ALL CASES TO THE TUBERCULOSIS UNIT OF THE HOSPITAL, FOR THEIR TRANSFER TO OTHER INSTITUTIONS, AND FOR THEIR DISCHARGE.

(See also section on Tuberculosis).

- (25.) THAT THE HOSPITALIZATION OF ACTIVE CASES OF TUBERCULOSIS BE INSISTED ON AS THE BASIC ESSENTIAL OF ANY EFFECTIVE PROGRAM FOR CONTROLLING TUBERCULOSIS.

The present failure to enforce quarantine for tuberculosis is one of the most vital weaknesses of the present tuberculosis control program. That quarantine for tuberculosis can be enforced when necessary is well attested to by the experience of Los Angeles and Sacramento. No program for the control of tuberculosis can hope to be successful if patients can sign out and leave the hospital almost at will. On the other hand, quarantine can not be enforced as long as the hospital itself discharges patients for disciplinary reasons. The positive sputum case

which leaves without permission is no more or less dangerous to his family and the community than the positive sputum case which is discharged from the hospital for disciplinary reasons.

As a means of helping to correct this situation, it is recommended:-

- (26.) THAT RECALCITRANT CASES OF TUBERCULOSIS BE SENT TO THE PSYCHIATRIC WARD OR TO THE LOCKED WARDS IN ISOLATION FOR A FEW DAYS AS A DISCIPLINARY METHOD RATHER THAN TO DISCHARGE THEM.
- (27.) THAT THE LAGUNA HONDA HOME BE REQUIRED TO OPEN UP ADDITIONAL INFORMARY WARDS AS A NECESSARY MEANS OF BRINGING ABOUT THE TRANSFER OF PATIENTS NOW AT THE SAN FRANCISCO HOSPITAL WHO SHOULD BE AT LAGUNA HONDA.
- (28.) THAT A SECOND CHIEF OPERATING ENGINEER BE EMPLOYED IN ORDER THAT THE SAN FRANCISCO HOSPITAL MAY HAVE THE EXCLUSIVE SERVICES OF AN ENGINEER.
- (29.) THAT A CLERK-STENOGRAPHER BE ADDED TO THE STAFF OF THE NURSING OFFICE AND THAT THE HALF-TIME CLERK-TYPIST NOW SERVING IN THAT OFFICE BE ASSIGNED TO NURSING INSTRUCTORS' OFFICE.
- (30.) THAT EVERY EFFORT BE MADE BY BOTH THE SAN FRANCISCO HOSPITAL AND THE CENTRAL OFFICE TO MINIMIZE THE CLERICAL WORK IN THE NURSING OFFICE.

In order to assist in the mental health rehabilitation program, which seems destined to be a problem of great magnitude at the close or even before the close of this war, it is recommended:-

(31.) THAT AS SOON AS FEASIBLE THE TWO CLOSED WARDS OF THE PSYCHIATRIC UNIT BE OPENED AND STAFFED, TO PROVIDE PSYCHIATRIC, DIAGNOSTIC AND TREATMENT SERVICE FOR THOSE CASES WHICH CAN BE BENEFITED BY MODERN, PSYCHIATRIC TREATMENT.

(32.) THAT THE PSYCHOPATHIC ORDINANCE BE CHANGED AND MODERNIZED IN SUCH MANNER AS WILL ELIMINATE THE UNNECESSARILY CUMBERSOME PROCEDURES NOW INVOLVED IN THE SO-CALLED DETENTION SERVICE AT THE PSYCHIATRIC UNIT.

LAGUNA HONDA HOME

The Laguna Honda Home is a very large county owned institution with several large, modern, well equipped buildings. Situated near the top of one of San Francisco's famous hills, the buildings and their spacious grounds are most attractive. By construction it has a capacity for caring for 2282 persons. It is an outgrowth of the former county almshouse.

Today the Home is said to have two major purposes: to provide a home for the aged and infirm and to furnish hospital care for the needy who are chronically ill. While the demand for both the home for the aged and for chronic hospital care has steadily increased in the past 10 years, the demand for hospital care has been the greater. Persons who are eligible can be admitted to the home for the aged rather promptly, but to find a bed in the hospital wards is much more difficult.

Personnel permitted in the budget totals 274. Actually employed on January 12, 1945 there were 231, which means that there were 16 per cent vacancies. The most serious shortages are among internes, orderlies and nurses. See Section on Personnel, Table 3.

Appropriations for the Laguna Honda Home for the fiscal year 1944-1945 total \$1,063,189.00 or \$1.37 per capita. Income from inmates and hospital patients totalled but about \$40,000.00 in 1944. This figure does not include a substantial amount, perhaps from \$20,000.-\$24,000., obtained from the sale of garbage.

The institution as a whole is administered by a Superintendent and an Assistant Superintendent. The hospital and clinic is managed by the Assistant Superintendent-Medical and the Superintendent of Nursing.

As previously pointed out, the capacity of the institution by construction is 2282. By present usage the capacity is 1902. The home for the aged and infirm has a capacity by construction of 1296 but 4 wards of 45 beds each are closed, thus making the present capacity 1116. The infirmary or hospital has a bed capacity by construction of 986 but 5 wards of 40 beds each are closed, making the present capacity 786. While there are frequently vacant beds in the home, the hospital is practically full all the time. The census of the entire institution (home and hospital) was 1833 on January 1, 1944; on January 1, 1945 the census was 1746.

Although the infirmary is supposed to be a chronic hospital, this is not entirely true in that 174 beds are set aside for surgical and medical cases who are acutely ill and therefore need considerably more medical and nursing care than those with chronic illnesses. On February 27, 1945 there were 775 patients in the hospital of which at least 164 or 21 per cent were acutely ill. This is one but only one of the reasons why it is impossible to transfer as many chronic cases from the San Francisco Hospital to Laguna Honda as would be desirable.

At Laguna Honda, in distinction from the San Francisco Hospital, there has been no attempt made to put extra beds in the wards as a means of making nursing and orderly care go farther. Admitting that the construction of the wards at Laguna Honda makes the placement of additional beds more difficult than at San Francisco, nevertheless, it would seem possible to put in some extra beds in each ward by closing the lower portion of some of the windows. (At present there is an interlocking hinge or bracket on the windows which makes it impossible to operate the lower and upper parts of the window independently. It should be possible to remove these hinges or change them.)

The 5 closed wards at the Laguna Honda Hospital, the fact that over 20 per cent of its beds are being used for acute rather than chronic cases, the failure to add any more beds to present wards, and the shortage of internes, nurses and orderlies all combine to create a very serious "bottle neck" at the San Francisco Hospital.

The Laguna Honda infirmary is supposed to be a chronic hospital, yet over 20 per cent of its cases are acute. The San Francisco Hospital is supposed to be an institution for the acutely ill, yet, in the middle of January, 1945, it was caring for (in acute hospital beds) 162 cases who had been recommended for Laguna Honda. That this is a very serious and costly "bottle neck" is obvious. Something ought to be done about this situation at the earliest possible moment. For a more detailed discussion see the section on the San Francisco Hospital.

The opening of two more wards in the Laguna Honda infirmary would greatly ease the situation. For months and months there has been discussion of opening these wards but nothing happens. Granted that man power shortages are very serious and that it is extremely difficult to obtain help, we can not but be impressed by the manner in which the San Francisco Hospital is meeting its equally difficult problem and the failure of Laguna Honda to meet its problem. We have the feeling that Laguna Honda does not want to open any more hospital wards and is not putting forth its best efforts to obtain the necessary help to open them. Why isn't it possible to interest the newspapers in pointing out the pressing need for more hospital beds

at Laguna Honda and the need for help to man them?

The Laguna Honda hospital is not as yet accredited as a teaching institution and for that reason it is difficult to recruit an adequate medical staff. Efforts should be made to have the hospital accredited. The hospital at Laguna Honda might well be designated as the Geriatrics Division of the San Francisco Hospital.

In thinking of the future of the Laguna Honda Home and the relationship of the Department of Public Health to it, one should consider San Francisco's very serious need for more hospital facilities for chronics and convalescents. Too many chronics and convalescents are now of necessity being cared for in hospitals for the acutely ill at considerably greater cost than they could be cared for in an institution specifically designed and staffed for that type of care. The administration of a home for the aged and infirm is not a proper function of a health department; it is distinctly a function of public welfare. At the conclusion of the war the Department of Welfare should be given the responsibility of providing care for the aged and infirm in some suitable institution. The need for this facility in San Francisco is especially great since the city has no municipal lodging houses. The Department of Public Health should use the entire Laguna Honda Home as a hospital for chronics and convalescents.

It is recommended:-

- (1.) THAT LAGUNA HONDA HOME BE REQUIRED, AT THE EARLIEST POSSIBLE TIME, TO OPEN TWO ADDITIONAL WARDS.
- (2.) THAT AN EFFORT BE MADE TO HAVE AT LEAST ONE ADDITIONAL INTERNE ASSIGNED TO LAGUNA HONDA.
- (3.) THAT LAGUNA HONDA BE REQUESTED TO EMBARK IMMEDIATELY ON AN AGGRESSIVE RECRUITMENT PROGRAM TO OBTAIN THE ADDITIONAL HELP REQUIRED TO OPEN TWO MORE HOSPITAL WARDS.

The newspapers might prove very helpful in this program.

The minimum help (in addition to the number now employed) necessary to staff the two additional wards if all the patients are to be bed patients would probably be 1 interne, 7 nurses, 12 orderlies, 1 porter and 2 kitchen helpers. If one ward is used for bed patients and the other for partially ambulatory patients the number might be reduced to 1 interne, 4 nurses, 8 orderlies, 1 porter, and 2 kitchen helpers.

- (4.) THAT LAGUNA HONDA PLACE EXTRA BEDS IN PRESENT HOSPITAL WARDS AS A MEANS OF MAKING PRESENT NURSING AND ORDERLY SERVICE GO FARTHER.
- (5.) THAT THE LAGUNA HONDA INFIRMARY OR HOSPITAL BE DESIGNATED AS THE GERIATRICS DIVISION OF THE SAN FRANCISCO HOSPITAL.
- (6.) THAT CONTINUED EFFORTS BE MADE TO HAVE THE LAGUNA HONDA HOSPITAL ACCEPTED AS AN ACCREDITED TEACHING INSTITUTION.
- (7.) THAT THE THREE EXISTING POSITIONS OF RESIDENT BE CHANGED TO ONE RESIDENT, ONE ASSISTANT RESIDENT AND ONE HOUSE OFFICER.
- (8.) THAT THE SOCIAL SERVICE DIVISION OF THE SAN FRANCISCO HOSPITAL, IN ADMITTING PATIENTS TO THE LAGUNA HONDA HOSPITAL, USE EVERY EFFORT TO TRANSFER PATIENTS FROM THE SAN FRANCISCO HOSPITAL RATHER THAN TO ADMIT THEM FROM THE OUTSIDE.

See also section on "San Francisco Hospital".

- (9.) THAT, AT THE CONCLUSION OF THE WAR, THE DEPARTMENT OF PUBLIC HEALTH DEVELOP THE ENTIRE LAGUNA HONDA HOME AS A HOSPITAL FOR NEEDY CHRONICS AND CONVALESCENTS.
- (10.) THAT THE RESPONSIBILITY FOR PROVIDING CARE FOR THE AGED AND INFIRM BE TRANSFERRED TO THE DEPARTMENT OF WELFARE.
- (11.) THAT FACILITIES IN THE OLD INFIRMARY AT LAGUNA HONDA BE MADE AVAILABLE, TO SOME REPUTABLE, NON-PROFIT ORGANIZATION, FOR CONVALESCENT CARE PROVIDED SUCH ORGANIZATION ASSUMES THE ENTIRE RESPONSIBILITY FOR BOTH STAFF AND MAINTENANCE.

THE HASSLER HEALTH HOME

Opened in the fall of 1927, the Hassler Health Home was essentially a rest home for convalescent ambulatory cases of tuberculosis with about 44 beds. In 1932 a new building was added which increased the bed capacity to 83. In 1941 two new buildings were added which boosted the bed capacity to 268. At this same time a third building was completed, the Children's Unit with 54 beds, but it has never been opened. It has its own kitchen and heating plant and is a modern, well equipped building.

The Hassler Health Home is at the top of a hill, some 5 or 6 miles from Redwood City, with a very fine view and beautiful grounds. The entire plant is most attractive, modern, well equipped, and provides excellent living conditions for its patients. The food is said to be excellent and certainly was on the occasion of our visit. The atmosphere of the Home is pleasant, cheerful and homelike, which is an important attribute to the progress and recovery of the patient.

Personnel of the Hassler Health Home totals 88 (which includes 2 part-time physicians, a part-time dentist and a half-time nurse). (See Table 4.) Positions allowed in the budget are 94 per cent filled. Professional personnel includes the Superintendent (actually the Chief of the Tuberculosis Control Division), the Assistant Superintendent, two other part-time physicians, 2 internes, a part-time dentist, the Superintendent of Nursing, 3 head nurses and $8\frac{1}{2}$ nurses, a laboratory technician, and a dietician. There are $3\frac{1}{2}$ nursing vacancies and 3 in orderlies.

Appropriations for the Hassler Health Home, for the fiscal year 1944-1945, total \$311,958.00 or 40.2 cents per capita. Income for the preceding fiscal year amounted to \$31,705.77 (from the State Tuberculosis Subsidy) or 4.0 cents per capita, thus reducing the use of city-county tax funds to \$280,252.23 or 36.2 cents per capita.

" The present Hassler Health Home, both in size and purpose, is very different from the Home as it was in 1927. Today the Home is a modern, well equipped and reasonably adequately staffed tuberculosis sanatorium.

All tuberculosis cases accepted for public hospital care in San Francisco should expect three phases of treatment. First, the initiation of treatment at the Tuberculosis Unit of the San Francisco Hospital, second, graduation to, and continuation of treatment at the Hassler Health Home and third, periodic check-ups after returning home. All tuberculosis cases, after the initiation of treatment at the Tuberculosis Unit, should be transferred to Hassler, except: (a) moribund cases, (b) cases needing tuberculosis surgery which can not be provided at Hassler, and (c) cases needing other special medical or surgical care not obtainable at Hassler. Tuberculosis patients should be taught to believe (and it is true) that graduation to Hassler constitutes an important forward step in their progress toward recovery. They should look forward eagerly to the time they can go to Hassler. Having seen both institutions, we should think that they would look forward to the pleasanter surroundings and more commodious living conditions at Hassler.

Of the 268 beds at Hassler, 223 are for men and 45 for women. At present (February 19, 1945) there are 189 patients. Thus there are 79 vacant beds at Hassler while there is overcrowding at the Tuberculosis Unit of the San Francisco Hospital. Every effort should be made to correct this situation.

The Children's Unit at Hassler might well be made available to the State Department of Health and the Heart Committee of the San Francisco Tuberculosis Association for the convalescent care of rheumatic fever cases, with the understanding that they will staff and maintain it. If the program proves successful the city should seriously consider taking it over at the end of two or three years.

For a considerably more detailed discussion of the entire tuberculosis control program, including recommendations concerning it, see the section on Tuberculosis.

EMERGENCY HOSPITAL SERVICE

The Emergency Hospital Service is administered by a Chief Surgeon (part time), an Assistant Chief Surgeon (part time), a Chief Steward and a Senior Steward. The service includes 6 emergency hospitals and their accompanying ambulance services.

The personnel of the Emergency Hospital includes the Chief Surgeon (part time), the Assistant Chief Surgeon (part time), the Chief Steward, a Senior Steward, 11 emergency hospital physicians, 15 nurses, 24 stewards, 20 ambulance drivers, and 2 stenographer-clerks, making a total of 76.

Altogether there are 18 ambulances in the emergency hospital service.

Appropriations for Emergency Hospital Service, for the fiscal year 1944-1945, total \$328,675.00. Actually, the cost is higher than this figure indicates since the medical and nursing services at the Mission Emergency Hospital are provided by the San Francisco Hospital.

San Francisco has the most completely developed system of municipally operated emergency hospitals within our knowledge. Starting with three rooms in the city prison and no ambulance service about 1873, these facilities have grown over the years to six well equipped stations now in operation. Four of these, though varying in capacity, are quite similar, occupying buildings specially constructed for the purpose. These are the Central, Harbor, Park, and Alemany Hospitals. The Mission Center occupies quarters in the San Francisco Hospital. The smallest unit, known as the Ocean Beach Hospital, located in the main building at the Fleishhacker Swimming Pool, is open only on week-ends, holidays, and in school vacations.

The largest unit is Central. This is housed in a two-story building adjoining the Department of Health headquarters at 101 Grove Street. There are two large treatment rooms, two male wards of 10 beds each, a female ward with 9 beds, a single room with one bed, a kitchen, a small supply room, and the administrative office quarters. Sterilizing equipment for large objects, such as blankets and mattresses, is located in the basement; also another ward, which could be used, of 7 beds. The Central Hospital is the administrative and operating headquarters of the Emergency Hospital Service.

The Harbor Hospital is located near the docks at 88 Sacramento Street. Here are two treatment rooms, a male ward of 8 beds and a female ward with 4 beds.

The Park Hospital is located in Golden Gate Park on Stanyan Street near Waller. Besides a treatment room, it has a male ward of 5 beds and a female ward of 2 beds.

The Alemany Hospital is located on Alemany Boulevard at Onondaga Avenue, near Mission Street. Besides two treatment rooms, there are 7 beds for males, 4 for females, one crib and 2 detention cubicles.

The Mission unit at San Francisco Hospital, on Twenty-second Street off Potrero Avenue, has two treatment rooms, two wards, each with 4 beds, and an overflow ward of 6 beds.

The Ocean Beach unit has a treatment room and one ward with 3 beds.

With the exception of the last named, each unit is equipped, for the most part, with ambulances and staff consisting of a surgeon, a steward, a nurse, and an ambulance driver on duty the full 24 hours. The size of the staff varies somewhat in the different units.

Altogether there are 18 ambulances, including 2 with staff for special calls in the county, transferring indigent patients to and from hospital and home, and other purposes. When not in use these ambulances are available for emergency duty.

At the head of the service, under the Director of the Department of Health, is a Chief Surgeon, an Assistant Chief Surgeon, and a Chief Steward.

It is evident that a great deal of thoughtful planning has been exercised in the administration of this service. The shifting of staff from one unit to another monthly to equalize the varying work load at the different units, the completeness of equipment of hospitals and ambulances, the specific written directions and procedures and allocation of responsibilities, the well kept ledgers of stewards and drivers, the skills demonstrated by stewards in handling injured and ill people, all bespeak effective planning and management.

Measured in terms of admissions to the various units, the volume of service for the Year 1943 (the latest report available), was as follows:-

Central	21,101 x	17681
Mission	19,887	42 984
Harbor	12,615	9 912
Park	10,148	12 382
Alemany	8,275	12 258
Ocean Beach	<u>639</u>	<u>888</u>
Total	<u>72,665</u>	<u>96105</u>

A sampling analysis was made of the work in three of the hospitals and the last annual statistical report was drawn on for data.

The Central
Emergency
Hospital.

In Central, the largest hospital, there were 21,101 admissions in 1943. This is an average of about 58 patients a day.

The length of stay in the hospital was recorded for 21,052. Eighty-seven per cent were out of the hospital in less than an hour. Thirteen per cent stayed over an hour but less than a full 24 hours, and only 21 patients of the entire 21,052 stayed longer than this.

The sampling for periods in June and October showed an average of 59 cases admitted daily, which indicates that the sampling gave a very close approximation of the annual figure. Of the 59 daily cases, 17 or 29 per cent were brought in by an ambulance (either the Central or from another emergency hospital), and 42 or 71 per cent either walked in by themselves or were accompanied by a friend, on foot, in a private car or taxi.

Of those brought in by ambulance, 65 per cent were accident cases. Of those walking in, 86 per cent were accident cases.

The Central ambulance returned 13 cases to Central Hospital, but it actually made 26 daily runs. Thus, on 13 of these daily calls, the ambulance either took the patient to another hospital, or the steward rendered first aid only, or the case was referred to a physician. Sometimes the patient refused to enter the ambulance. Often when the ambulance arrived there was no case to be found. In a number of instances the patient was found dead. Some ambulance runs were made for

purposes unconnected with an emergency, such as taking the car for repairs. On those runs where the ambulance did not return the patient to the Central Hospital, the circumstances are expressed in percentages, thus:

Taken to Mission Emergency Hospital	23.
Taken to other Emergency Hospitals	11.
Taken to private or government hospitals	2.
No cause for ambulance run	21.
Case refused to enter ambulance	11.
Case found dead on arrival	9.
Errands other than for case	8.
Rendered aid or advice only	6.
Own physician already there or summoned	6.
Referred to City Physician	3.
Other reasons	-1.

In many instances, it will be noted, there was no really justifiable reason for an ambulance to have made the trip. However, this could not very well be avoided because the facts were not known when the call was received.

To add to the picture further, we may present the percentage distribution of cases received in the Central Hospital shown by the location of the accident or illness, and with these facts given separately for those brought in by an ambulance and those who walked in. (Figures are from sample count for two separate periods in June and October).

	Brought by Ambulance	Walked in
" Total Cases received	232	587
Accidents - at home	10.	33.
- at work	2.	5.
- auto accidents	13.	5.
- street car accidents	12.	-1.
- others (mainly on street)	28.	42.
Non-Accidents (illness)		
- at home	10.	9.
- at work	-1.	-1.
- other	24.	5.

While the place of accident varies, the chief site is on the street rather than at home or at work. A larger proportion of those having accidents at home walk into the hospital rather than call an ambulance. For auto and street car accidents, the ambulance usually transports the case. Not many of either accidents or illness in this group occur at work. It is accidents of various kinds, rather than illness, that bring cases into the Central Emergency Hospital.

We may sum up briefly the foregoing experience at Central Emergency Hospital, as follows:-

A very substantial number of cases are received, averaging about 58 a day over the year.

The stay in the hospital is brief, usually less than an hour.

From two to three times as many cases walk in as are brought in by an ambulance.

In only half of the ambulance runs is the case returned to Central Hospital.

A third of the ambulance runs are not altogether necessary, but this can not be avoided.

Most cases received at the hospital are accident cases rather than non-accident.

More cases brought in - either accident or non-accident - occur on the street (that is, the sidewalk), rather than at home or at work.

Park and Alemany
Emergency Hospitals.

Both Park and Alemany Hospitals present a picture quite different in many respects from Central. Thus, the average daily admissions for the Year 1943 were much less than in Central.

Central 58.

Park 28.

Alemany 23.

The average daily admissions for the period sampled in June and October, 1943 were:

Central 59.

Park 26.

Alemany 23.

The close approximation of the sampling to the yearly average is again indicated.

Over the Year 1943 the stay of cases in the emergency hospital was shorter in Park and Alemany. The percentage staying more than one hour was:

Central 13.

Park 5.

Alemany 5.

Incidentally, the corresponding percentage at Mission was 40, and for Harbor 16. The most severe cases evidently went to Mission.

In the entire year only 2 cases at Park and 1 at Alemany stayed there more than a day. The corresponding number at Central was 21, at Harbor 5, and at Mission 280.

Less people relatively were brought in by ambulance at Park and Alemany. Most of them walked in alone or with a friend. Using the samplings for similar periods in June and October, we get this comparison:

	Central	Park	Alemany
Average daily admissions	59	26	23
- brought in by ambulance ★	17	4	2
- walked in	42	22	21
<u>Percentage brought in</u> by an ambulance	29.	15.	9.

As was mentioned in describing Central Hospital, the ambulance makes many runs without bringing a case back to its own hospital. The daily average runs and the average number of runs (as sampled for June and December) on which a case was returned to its own hospital were:

	Central	Park	Alemany
Runs	26	12	11
Case returned	13	5	2

Thus, the Alemany ambulance brought only 2 cases a day to that hospital and the Park ambulance only 5 to its hospital.

Of the ambulance runs in which no case was returned to the home hospital, this was the outcome: (Page 163) (sampling)

★ This included the ambulance of that hospital or of other emergency hospitals.

Percentage distribution for each hospital ambulance.

	Central	Park	Alemany
Case taken to - Mission	23.	14.	39.
- Other emergency hospitals	11.	19.	7.
- Other hospitals	2.	5.	1.
Ambulance used for special errands other than transporting case	8.	11.	23.
Other reasons	56.	51.	30.

Thus, on the ambulance runs in which no case was returned to its own hospital, the Alemany ambulance was being used a good share of the time in transporting cases to Mission Emergency Hospital. The Park ambulance, on the other hand, was taking more cases to other emergency hospitals than Mission. The Alemany ambulance was also being used an appreciable amount of time on special errands, such as transporting laundry.

The last line, "Other reasons" covers a variety of circumstances, some of which represented fruitless runs for the ambulance. We can split up these percentages, 56., 51., and 30., into their parts, as follows:-

	Central	Park	Alemany
No cause for ambulance run	21.	16.	10.
Case refused to enter ambulance	11.	5.	5.
Case found dead on arrival	9.	8.	6.
Rendered aid or advice only	6.	8.	2.
Own physician already there or summoned	6.	11.	7.
Referred to City Physician	3.	2.	0.
Other reasons -fire, military patrol	-1.	-1.	-1.
Total	56.	51.	30.

The "no cause" item means either that the case could not

be found at the address, or he had already left, or that the Police Patrol or another ambulance had already taken him. Central had a greater proportion of such fruitless calls than the others. It also had double the proportion of "refusals". Park had more cases in the "own physician" group.

Of the admissions to the hospital who walked in, the percentage distribution by accident or non-accident causes was as follows:-

	Central	Park	Alemany
Accidents - at home	33.	49.	54.
- at work	5.	4.	2.
- auto accidents	5.	3.	2.
- street car accidents	-1.	1.	-1.
- other (street, school or play)	42.	33.	31.
Non-Accidents- at home	9.	9.	9.
- at work	-1.	0	-1.
- other	5.	1.	2.

Park and Alemany have a greater proportion of home accident cases walking in to the hospital than does Central, and less street accident cases. The majority of the "other" accident cases at Alemany are children hurt at school or play.

A difference in the emergency hospital districts is also reflected in the percentage of hospital admissions for "intoxication" and the milder, less certain term, "alcoholic breath". Thus, over the entire Year 1943 the percentages are:-

Central 20. Park 7. Alemany 5.

The corresponding figure for Harbor is 29, and for Mission 9. Accidents and illness are associated with over-indulgence in alcohol in much less degree at Park and Alemany and Mission than at Harbor and Central.

An attempt was made to classify the causes of hospital admissions at Park and Alemany in terms of "major" and "minor" injury or illness. A week's period in June and October was used. This was not altogether easy to do from the brief entry in the steward's book. If there was doubt, the cause was tabulated in the "major" list. In the "minor" list were such items as simple injuries to the thumb or fingers, such as a sliver or cut or abrasion, sprained ankle or hand, insect bites, conjunctivitis, headache and the like. This was purely a subjective classification

be found at the hospital, or he had already left, or that the Police
 Patrol or another ambulance had already taken him. General had a
 greater proportion of these patients than the others. It
 also had the reputation of "retards". Park had more cases
 in the "own physician" group.

Of the patients to the hospital who walked in, the
 percentage distribution by accident or non-accident cases was
 as follows:-

Accidents - at home	Central 20.	Park 7.	Albany 2.
- at work	33.	49.	24.
- other accidents	5.	1.	2.
- street and sidewalk	5.	3.	2.
- other (e.g., school or play)	1.	1.	1.
Non-Accidents - at home	42.	33.	31.
- at work	9.	9.	9.
- other	1.	0.	1.
	5.	1.	2.

Park and Albany have a greater proportion of home
 accident cases walking in to the hospital than does Central, and
 less street accident cases. The majority of the "other" accidents
 cases at Albany are children hurt at school or play.

A difference in the percentage distribution is
 also reflected in the percentage of hospital admissions for
 "intoxication" and the mild, like central, but "intoxication"
 "breath". Thus, for the Central Year 1943 the percentages are:-

Central 20. Park 7. Albany 2.

The corresponding figures for Harbor is 29, and for
 Mission 9. Accidents and illness are associated with over-
 indulgence in alcohol in each case, but at Park and Albany
 and Mission than at Harbor and Central.

An attempt was made to classify the cases of hospital
 admissions of Park and Albany in terms of "major" and "minor"
 injury or illness. A week's record in June and October was used.
 This was not altogether easy to do as the first entry in the
 records' book, if there was one, the name was tabulated in
 the "major" list. In the "minor" list were such items as simple
 injuries to the hand or foot, such as a blow on the eye or
 abrasion, sprained ankle or wrist, minor cuts, contusions,
 headache and the like. This was possible only after a careful

by the surveyors and can not be regarded as more than a rough estimate. However, the tabulation leaned over backward in calling a doubtful injury "major" rather than "minor". The tabulation gave this percentage distribution:-

	<u>Ambulance Cases</u>		<u>Walked in</u>	
	Major	Minor	Major	Minor
Park	84.	16.	45.	55.
Alemany	94.	6.	42.	58.

To sum up the situation with respect to Park and Alemany Hospitals, each has less than half the admissions of Central.

The cases received are less critical, in so far as this may be judged by the shorter stay in the hospital. This is also borne out by the fact that whereas 71 per cent of cases walked in to Central, 85 per cent walked in to Park and 91 per cent to Alemany. Thus, the people coming to Park and Alemany, or at least most of them, could have gone to private physicians (if private physicians were available, which is not the case now in war time) or to near-by private hospitals. These areas are indicated to be of higher economic status in which people would be able to pay for service.

The ambulance at Central returned 13 cases daily to its own hospital. The ambulance at Park and Alemany returned only 5 and 2 cases, respectively, daily to their own hospitals.

Whereas 49 per cent of the total ambulance runs at Central were for purposes other than returning the case to its own hospital, the corresponding percentages at Park were 59 and at Alemany 80. The Alemany ambulance is now used much more than the others for special errands, laundry, etc. for all the hospitals.

A substantial proportion of the admissions to Park and Alemany are for minor causes. Of the 26 cases admitted daily to Park, 13 were for "minor" cause, the classification being very strict in labelling a "minor" cause and liberal in labelling a "major" cause. Of the 23 cases admitted daily to Alemany, 12 were for minor causes. (Sampling studies).

To illustrate these minor injuries, the following are examples taken from the steward's book:-

	<u>Minutes in Hospital</u>
Laceration of lower lip, playing football	4
Sprained left thumb, fall from swing	5
Hemorrhage under finger nail	15

	<u>Minutes in Hospital</u>
Small incised wound palm, right hand	5
Laceration of left thumb	15
Headache	5
Sprained feet, fall at home	10
Bean in left ear	4
Laceration left eyebrow - contusion	6
Tooth extraction (for packing) ambulance case	31
Pharyngitis	10
Button in nose	5
Sciatica	10
Injured finger on door	10
Sliver in leg	6
Ran into door - cut lower lip	10
Flea bite in back	10
Impetigo	5
Ringworm on leg	10
Constipation	12
Eczema - left ear	10

In contrast to the above, examples of cases that might be of minor nature but were classed by us as "major" injuries, in order to be on the safe side, were:-

Contusion of right forearm, playing football	10
Contusion of forehead	5
Contusion of mouth, ran into bench while playing	5

As we review the situations at Park and Alemany, a question is raised as to the necessity for these services in ordinary times. Do the causes for which they are used justify a special emergency hospital with an ambulance in these areas? Are they justified relatively when compared with certain unmet

needs in other areas of the public health and medical care program? How could these injuries and illnesses be handled if these Emergency hospitals were not present?

When a person sustains an injury, regardless of severity, and blood is flowing, or when a person is found unconscious on the sidewalk, the first thought is quick attention by some capable person. In normal peace times, in cases where the person is able to walk, one would think of the nearest private doctor's office. But today doctors are scarce and those on duty are unusually busy.

Furthermore, the nearest doctor's office is not generally known. Some permanently located, well-known center best serves the purpose. The emergency hospitals are known. It is known that they can be called for an ambulance. This meets the situation admirably. Of course there are many private hospital centers known to which one might turn. Such centers may or may not be able to send an ambulance quickly.

But even in normal times when private doctors are more plentiful, there are hours of the day when the doctor is out on calls. His service is thus less available than an emergency hospital which is open at all hours with a staff on duty. If physicians practiced in groups and one of the physicians was always in the office, this would better serve emergency situations. But this is not common and the often unsightly emergency case might not always be welcome in the waiting room of a private office.

Thus, there is no question but what the emergency hospital meets the situation most satisfactorily. It is this reason that justifies the existence of the Central, and the Mission, which can conveniently feed cases into San Francisco Hospital. Harbor is also included in this group because of the very special problems encountered on the water front.

The only doubt relates to Park and Alemany. This doubt is not a reflection on the character of the service but is raised because of the possibility that other satisfactory arrangements could be worked out to meet the needed service in these areas at a considerable saving in expense to the city.

The alternatives, that could be effected, and we are speaking now not of the present period but at the conclusion of the war, are services at the hands of private physicians for which most people in these areas, seemingly, could afford to pay. Many of the services now rendered at the emergency hospitals are in the nature of outpatient, rather than strictly emergency, services.

There are private hospitals in the near vicinity which, even if they do not do so now, could provide the small amount of outpatient and emergency care, both pay and free, other than that which could be absorbed by private physicians. We believe that these hospitals would be glad to provide service for emergency cases if asked to do so. X

Ambulance service could be provided from Central. The city is not too large for this purpose. The difference in time in responding to a call would be a matter of minutes, 5 or 10 at the most. The average time of an ambulance run from the time of leaving the hospital to return to the hospital is 17 minutes at Central, 23 minutes at Park, and 31 minutes at Alemany. The last named is much higher because this ambulance is used frequently on long calls for various purposes outside the district.

Much of the time of the ambulance at Park and particularly at Alemany is spent in purposes other than to return the case to that hospital. Except for the fact that it is available, it does not require an ambulance to do some of the errand work that is now done with the Alemany ambulance. This suggested change might call for transferring one of the ambulances to Central. It would probably not mean any further addition to the present staff at Central.

The service at all the emergency hospitals is not steadily increasing. Other than Harbor, where the load has increased about 25 per cent, the admissions elsewhere are about what they were 5 years ago.

The Ocean Beach is small with annual admissions around 700 a year. It might well be continued.

We are fully aware that the average daily ambulance calls do not tell the whole story for this will vary from day to day. In scanning the driver's book at Central, the daily calls ranged from a minimum of 9 to a maximum of 33. It is believed that the ambulance service at Central with the possible addition of one ambulance could well meet this fluctuation and the capacity of the hospital is undoubtedly adequate for the purpose.

If plans for pre-paid medical care are adopted by the State, the costs will be fairly well met for those heretofore unable to face private physician, or private hospital outpatient, paid service.

The estimated saving in cost to the city can not well be stated in advance because the adjustments would have to be worked out in detail from intimate experience. On the basis of saving in staff salaries alone relative to total staff in the

entire emergency hospital service, it is estimated that this would be in the neighborhood of \$70,000.00 to \$90,000.00 dollars annually.

At present an ambulance crew consists of a steward and a driver. The steward is trained in the handling of sick and injured people; the driver is not. Since both medical stewards (at present called stewards) and drivers receive the same rate of pay, it would seem far better to have two medical stewards, one of whom should qualify as a chauffeur, than to continue with the present type of crew.

It is suggested that 18 months be allowed in which to make this transition. All new appointees should be required to qualify as medical stewards (at present designated as stewards). Presently employed ambulance drivers should be given the opportunity, providing they are willing and capable, of qualifying as medical stewards within the next 12 months. If at the end of 12 months they have endeavored to qualify but have failed to do so they should be given 6 more months in which to transfer to other positions. Thus, an ambulance driver who makes no attempt to qualify as a medical steward would terminate his present position at the end of 12 months. Those who tried and failed to qualify would be given an additional 6 months in which to effect transfers or obtain new positions.

An inservice training program conducted by the Department of Health would prove extremely helpful in assisting candidates to qualify as medical stewards.

The title steward, to many persons, connotes an association with a kitchen and therefore gives an erroneous impression of what that person's functions are. As a result of this false impression, occasioned by the title, the public may have a lack of confidence in the person's ability to aid the sick or injured. As a matter of fact, most of the stewards have had a good deal of experience and merit a confidence of which they may now be deprived.

As a means of developing a confidence on the part of sick or injured persons, who may need emergency service, in the persons who are to give that service and who have passed qualifying examinations to render the service, it would seem wise to change the title of steward to medical steward.

It is recommended:-

- (1.) THAT THE SERVICES AT CENTRAL, MISSION,
AND HARBOR EMERGENCY HOSPITALS BE
CONTINUED AS AT PRESENT.

(2.) THAT AS SOON AS PRACTICABLE, AFTER THE CONCLUSION OF THE WAR, AND NOT UNTIL THEN, THE PARK AND ALEMANY EMERGENCY HOSPITALS BE CLOSED, BUT THAT AMBULANCE SERVICE FOR THESE AREAS BE PROVIDED FROM CENTRAL AND MISSION.

(3.) THAT EACH AMBULANCE CREW BE COMPOSED OF TWO MEDICAL STEWARDS (NOW CALLED STEWARDS), ONE OF WHOM SHALL BE QUALIFIED AS A CHAUFFEUR, INSTEAD OF, AS AT PRESENT, AN AMBULANCE DRIVER AND A STEWARD.

(4.) THAT AN INSERVICE TRAINING PROGRAM BE ESTABLISHED IN THE DEPARTMENT OF PUBLIC HEALTH TO ASSIST IN TRAINING MEDICAL STEWARDS AND CANDIDATES FOR SUCH POSITIONS.

(5.) THAT THE TITLE OF STEWARD BE CHANGED TO MEDICAL STEWARD.

At present, occasionally, when a steward, henceforth designated as medical steward, is sick or otherwise absent, two ambulance drivers are sent out on a call. In such instances, there is obviously no one qualified to give aid to the sick or injured. There are possibilities of serious difficulties in such situations. As a means of preventing such possible difficulties, it is recommended:-

(6.) THAT WHENEVER A MEDICAL STEWARD IS ABSENT FROM DUTY ANOTHER MEDICAL STEWARD BE ASKED TO WORK OVERTIME SO AS TO INSURE ONE QUALIFIED PERSON BEING PRESENT ON EACH AMBULANCE CALL.

THE CITY PHYSICIANS' OFFICE.

For purposes of providing home medical care and diagnostic service to the medically needy, the city has been divided into six districts. The City Physicians' Office is in the Department of Health, with headquarters in the Social Service Division of the San Francisco Hospital, and is responsible directly to the Director of Public Health.

Personnel of the City Physicians' Office consists of the Supervising City Physician (who also serves one of the six districts), 5 district city physicians, 2 night physicians, 2 physicians who work week-ends and holidays, and one physician who serves the prison, making a total of 11. They are all part-time physicians although the 6 day physicians are "on call" and "stand by" service from 8:30 A.M. to 5:30 P.M. from Monday through Friday and from 8:30 until noon on Saturday. This means that sick calls may be given them during these hours. Calls given them the latter part of the afternoon will obviously have to be made in the evening. The two night physicians work alternate nights and are on duty to receive calls from 5:30 P.M. until 10:30 P.M. Calls received up to 5:00 P.M. are received and relayed to the City Physicians by the Social Service Division at the San Francisco Hospital. Calls after 5:00 P.M. are received and relayed by the Central Emergency Hospital. Calls received after 10:30 P.M. are taken care of by the Emergency Hospital Service.

Appropriations for the City Physicians' Office for the fiscal year 1944-1945 total \$48,560.00 or 6.3 cents per capita.

During 1944 visits made by the city physicians totalled 10,038. Of this number 6150 were made by the 6 day physicians or an average of 1025 visits per physician. The two night physicians made 1073 visits or 537 each. The two physicians on duty on week-ends and holidays made 699 visits or 349 each. The physician serving the prison made 2116 calls. Visits made by the 6 day city physicians thus cost slightly over \$4.00 per visit.

There seems no doubt but that the provision of home medical care results in a very substantial saving in hospital care. In all probability the saving in hospital care is

greater than the cost of the service.

There is one inherent difficulty in this, as in all other city physicians' service which is provided by a fixed number of physicians. The staff which is adequate to provide reasonable care in times when sickness rates are normal is totally inadequate to provide sufficient care when there is a sudden sharp increase in sickness such as occurs in an outbreak of influenza. The only solution to this problem seems to lie in having a flexible staff and the procurement of a flexible staff is practically impossible in war times.

There are two other weaknesses of the program here. One is that the program lacks full time direction which could do so much to check up on the effectiveness of service and which would insure prompt attention for the occasional or rare emergency case in which it is impossible to obtain the immediate services of one of the city physicians. The second is that, while city physicians are supposed to and usually do telephone in with reasonable frequency, there is not as definite a plan of telephoning in as would be desirable.

It would seem to the best interests of the service to place the Chief City Physician (now designated as the Supervisor of City Physicians) on a full-time basis and have him also act as the medical admission officer in the Social Service Division at the San Francisco Hospital; to institute a more definite plan of telephoning in to receive and report upon calls, and to, as soon as feasible, add 4 or 5 emergency city physicians on a small monthly retaining fee basis with the understanding that they would assume city physicians' duties when needed at the prevailing rate of pay for city physicians. Some such plan would seem to be the only method of assuring extra service when such service is necessary. These extra emergency city physicians might form a nucleus for staffing the emergency centers of the Citizens' Protective Corps. It is practically impossible to recruit physicians after an increase in sickness occurs.

There are two other alternative methods of improving the service after the war is over. One would be to retain a full-time Chief City Physician to administer a plan by which sick calls for needy persons would be made by a panel of physicians, consisting of all licensed and reputable physicians who wished to participate, to be paid on an agreed upon fee basis. Such a plan would obviously provide the flexibility of rendering service which is lacking in the present program. The other plan would be, after the war, as present city physicians retire, to replace them with young physicians, who are endeavoring to establish themselves, with appointment for only two or at most three years. While it is realized that this plan would sacrifice

something in terms of the medical experience of older physicians, it would gain in the interest and effort which the young physician would put into the job. For the young physician trying to establish himself the city physician's job would be important and he would have both the time and the interest to put forth his best efforts.

It is recommended:-

- (1.) THAT THE CHIEF CITY PHYSICIAN (NOW DESIGNATED AS SUPERVISING CITY PHYSICIAN) BE EMPLOYED FULL TIME AND THAT HE ALSO ACT AS THE MEDICAL ADMISSION OFFICER IN THE SOCIAL SERVICE DIVISION OF THE SAN FRANCISCO HOSPITAL.
- (2.) THAT A MORE DEFINITE PLAN BE ESTABLISHED FOR CITY PHYSICIANS TELEPHONING IN TO RECEIVE NEW CALLS AND TO REPORT UPON CALLS ALREADY MADE.
- (3.) THAT, AS SOON AS FEASIBLE, 4 OR 5 EXTRA EMERGENCY CITY PHYSICIANS BE ADDED TO THE STAFF, ON A SMALL MONTHLY RETAINING FEE BASIS (PERHAPS \$25. A MONTH), WITH THE UNDERSTANDING THAT THEY WOULD ASSUME CITY PHYSICIANS' DUTIES WHEN NEEDED AT THE PREVAILING RATE OF PAY FOR CITY PHYSICIANS.
- (4.) THAT, AT THE CONCLUSION OF THE WAR, CONSIDERATION BE GIVEN TO THE ADOPTION OF ONE OF THE ALTERNATIVE PLANS SUGGESTED IN THE PRECEDING DISCUSSION.

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